



# KidsLink

Neurobehavioral Center

## Developmental History Form

Dear Family,

Thank you for your interest in diagnostic evaluation and assessment services offered at KidsLink Neurobehavioral Center. So that we can make the best use of time during your appointment, please complete the following Developmental History Form. Once completed, please fax or mail the form (2132 Case Parkway North, Suite A, Twinsburg, Ohio 44087) to us so we may review the information prior to your appointment. Thank you for taking the time to provide us with this information, and we look forward to working with your family!

What is the main reason you are seeking evaluation at this time? What are the chief concerns that you would like help with? \_\_\_\_\_

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### I. General Information

Child name (last, first)	Nickname	Age	Grade	Birthdate
Person completing form		Relationship		Today's date
Parent/Guardian		Home phone		Work phone
Address		City		State Zip
2 <sup>nd</sup> Parent/Guardian		Home phone		Work phone
Address (if different from above)		City		State Zip
Child's birthplace		Adopted? Yes    No		If child was adopted, age at adoption

### II. Family Background:

**A. Birth Parents: This section pertains to the child's biological parents only. If you are not the child's birth parent, please complete as accurately as you can.**

Birth mother's name:	Present age:
Highest level of formal education completed and degrees/certificates earned:	Current profession/occupation:

Live with child full time? Yes No	Marital status: Married Separated Widowed Divorced Single, never married
Birth father's name:	Present age:
Highest level of formal education completed and degrees/certificates earned:	Current profession/occupation:
Live with child full-time? Yes No	Marital status: Married Separated Widowed Divorced Single, never married
Child resides with: Birth mother & father Birth mother only Parent & stepparent Birth father only Parent & adoptive parent Adoptive parent(s) Foster parent(s) Other adults living in child's primary home:	If child lives with only one parent, contact with other parent is: Frequent (sees child more than 4 days per week) Occasional (sees child at least once per week) Minimal (sees child less than once per week) None

**B. Siblings and Birth Order:** List the names and ages of each sibling in birth order, oldest child first, including relationship to the child (i.e., natural, half-sibling, step-sibling)

Name:	Age:	Male/Female	Relationship:(natural, half-sibling, step-sibling)
1.			
2.			
3.			
4.			

**C. Familial History of Learning, Behavior, Mental Health and Neurologic Problems**

Indicate whether any member of the *child's IMMEDIATE biological family* (i.e., parents and siblings) experienced any of the following. Please check all that apply.

Difficulty	Relationship to Child	Difficulty	Relationship to Child	Difficulty	Relationship to Child
autism		compulsive behaviors		learning disability	
asperger disorder		obsessive behaviors		special education	
inattention		anxiety		mental retardation	
hyperactivity		depression		social difficulty	
language delays		bipolar disorder		down's syndrome	
verbal apraxia		schizophrenia		epilepsy	
headache		tics		cerebral palsy	
other		other		seizures	

Please list any other brain, spinal cord, nerve problems, cancer, stroke or heart attacks before age 70:

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Between ages 3 and kindergarten did your child receive any therapies? If so please describe:

**Elementary School Years:**

Kindergarten:	special education classroom	inclusion setting	regular education
1 <sup>st</sup> grade:	special education classroom	inclusion setting	regular education
2 <sup>nd</sup> grade:	special education classroom	inclusion setting	regular education
3 <sup>rd</sup> grade:	special education classroom	inclusion setting	regular education
4 <sup>th</sup> grade:	special education classroom	inclusion setting	regular education
5 <sup>th</sup> grade:	special education classroom	inclusion setting	regular education
6 <sup>th</sup> grade:	special education classroom	inclusion setting	regular education

Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

**Middle School Years:**

Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

**High School Years**

Have teachers reported any concerns regarding academic and/or behavioral difficulties? If yes, please explain:

**IV. Medication History:**

List current and past medication (OTHER THAN “routine” medications, e.g., antibiotics for ear infections, fever medications, etc)

Is the child presently on medication?	Yes	No	Prescribed for:	(Helpful, Not Helpful)	Outcome	Unusual reaction
Name of medication						
1.						
2.						
3.						

Has the child previously been on medication?	Yes	No	Prescribed for:	(Helpful, Not Helpful)	Outcome	Unusual reaction
Name of medication						
1.						
2.						
3.						

Please indicate any drug allergies: What problems did the allergy cause?

1.

2.

Please list any alternative therapies, home remedies, dietary supplements:

**V. Medical History:**

Has your child had any of the following? If yes, please explain.

<b>Problem:</b>	<b>If yes, please check</b> ✓	<b>Please explain:</b>
Staring spells		
Seizures (with or w/o fever)		
Head trauma		
Headaches		
Speech problems		
Tics or repeated movements		
Weight loss		
Rapid weight gain		
Trouble with appetite		
Unexplained fevers		
Vision problems		
Hearing problems		
Heart problems		
Hay fever/asthma		
Lung problems		
Diarrhea or constipation		
Stomach or bowel problem		
Urinary tract infections		
Kidney problems		
Broken bones or joint problems		
Skin problems		
Birth marks		
Endocrine problems		
Anemia (low blood)		
Immunologic problems		
Immunization reactions		

Other?		
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For girls: age at first menstrual period or none: \_\_\_\_\_ Regular? Yes No

**VI. Evaluation History:**

Has your child participated in any assessments/evaluations or received treatment through a private professional, school or other agency? If yes, please list in order:

Name of Professional/Organization:	Purpose:	Report available?	Date of testing:
	Diagnosis:	Yes No	
Name of Professional/Organization:	Purpose:	Report available?	Date of testing:
	Diagnosis:	Yes No	
Name of Professional/Organization:	Purpose:	Report available?	Date of testing:
	Diagnosis:	Yes No	
Name of Professional/Organization:	Purpose:	Report available?	Date of testing:
	Diagnosis:	Yes No	
Name of Professional/Organization:	Purpose:	Report available?	Date of testing:
	Diagnosis:	Yes No	

Has your child had any EEG's, CT scan, or MRI scans?

**EEG** Yes No If yes, when: \_\_\_\_\_ where: \_\_\_\_\_  
outcome: \_\_\_\_\_

**CT** Yes No If yes, when: \_\_\_\_\_ where: \_\_\_\_\_  
outcome: \_\_\_\_\_

**MRI** Yes No If yes, when: \_\_\_\_\_ where: \_\_\_\_\_  
outcome: \_\_\_\_\_

**Child's Ethnicity** (This section is voluntary. Check all that apply.)

African American	Caucasian	Native American	Other
Asian American (Chinese, Japanese, Korean, Filipino)	Latino/Latina	Indian Subcontinent/ Middle Eastern	

***Thank you for completing the form.  
This information will assist in the providing the best care for your child.***