



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 (330-963-8680) or mail the form (8054 Darrow Road, Building D, Suites 5 and 6, 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? _____

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 nd Parent/Guardian		Home phone		Work phone
Address (if different from above)		City		State Zip
Child's birthplace		Adopted? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single, never married
Child resides with: <input type="checkbox"/> Birth mother & father <input type="checkbox"/> Birth mother only <input type="checkbox"/> Parent & stepparent <input type="checkbox"/> Birth father only <input type="checkbox"/> Parent & adoptive parent <input type="checkbox"/> Adoptive parent(s) <input type="checkbox"/> Foster parent(s) <input type="checkbox"/> Other adults living in child's primary home: _____	If child lives with only one parent, contact with other parent is: <input type="checkbox"/> Frequent (sees child more than 4 days per week) <input type="checkbox"/> Occasional (sees child at least once per week) <input type="checkbox"/> Minimal (sees child less than once per week) <input type="checkbox"/> 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
<input type="checkbox"/> autism		<input type="checkbox"/> compulsive behaviors		<input type="checkbox"/> learning disability	
<input type="checkbox"/> asperger disorder		<input type="checkbox"/> obsessive behaviors		<input type="checkbox"/> special education	
<input type="checkbox"/> inattention		<input type="checkbox"/> anxiety		<input type="checkbox"/> mental retardation	
<input type="checkbox"/> hyperactivity		<input type="checkbox"/> depression		<input type="checkbox"/> social difficulty	
<input type="checkbox"/> language delays		<input type="checkbox"/> bipolar disorder		<input type="checkbox"/> down's syndrome	
<input type="checkbox"/> verbal apraxia		<input type="checkbox"/> schizophrenia		<input type="checkbox"/> epilepsy	
<input type="checkbox"/> headache		<input type="checkbox"/> tics		<input type="checkbox"/> cerebral palsy	
<input type="checkbox"/> other		<input type="checkbox"/> other		<input type="checkbox"/> seizures	

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

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III. Child's Birth History: (Please respond to all items)

Were any chemical substances consumed during pregnancy? <input type="checkbox"/> cigarettes <input type="checkbox"/> alcohol <input type="checkbox"/> marijuana <input type="checkbox"/> other _____		
Were there any concerns during pregnancy, labor, and delivery? If yes, please explain:		
How was your child delivered? <input type="checkbox"/> vaginal birth <input type="checkbox"/> cesarean section	How many weeks gestation was your child at birth? _____	
How many days after birth was infant released from the hospital? _____ Infant's weight at birth: _____		
Head Circumference, if known. If unknown, please check with your pediatrician: at 1 month: _____ at 6 months: _____ at 12 months: _____ at 18 months: _____		
Please check all that apply:	<input type="checkbox"/> oxygen	<input type="checkbox"/> incubator
<input type="checkbox"/> NICU hospitalization # of days _____	<input type="checkbox"/> problems sucking/feeding	<input type="checkbox"/> antibiotic treatment
<input type="checkbox"/> jaundice <input type="checkbox"/> biliruben lights or blankets	<input type="checkbox"/> infantile seizures	<input type="checkbox"/> other; Please explain

IV. Developmental History: If your child has **not acquired** the skills, please print "na" in the box.

Handedness: Right Left

Motor Milestones:	Age Acquired:	Motor Milestones: Continued	Age Acquired:	Speech/Language Milestones:	Age Acquired:
Roll		Get dressed		Smiling	
Sit up unsupported		Pedal a tricycle		Babbling	
Crawl		Pedal a 2 wheeler		Pointing	
Independent Walking		(no training wheels)		1st words	
Independent Toileting		Tie shoes		2-3 words paired	

V. Education History

Early Intervention? (ages 0-3) If yes, check all that apply and indicate how often (i.e., 1 hour/weekly)				
<input type="checkbox"/> Speech/language therapy How often: _____	<input type="checkbox"/> Occupational therapy How often: _____	<input type="checkbox"/> Physical therapy How often: _____	<input type="checkbox"/> Consultation with "Interventionist" How often: _____	<input type="checkbox"/> Structured Play/Social Group How often: _____
Please describe any other types of therapies during ages 0-3:				

Was a multi-factored evaluation completed at age 3? Yes No

If yes, by which school district: _____

Preschool (year 1): <input type="checkbox"/> special education <input type="checkbox"/> inclusion setting <input type="checkbox"/> private community preschool
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:
Preschool (year 2): <input type="checkbox"/> special education <input type="checkbox"/> inclusion setting <input type="checkbox"/> private community preschool
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:
Preschool (year 3): <input type="checkbox"/> special education <input type="checkbox"/> inclusion setting <input type="checkbox"/> private community preschool
Did staff relate any concerns to you about your child's development or classroom behavior? If so, please describe:

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

Elementary School Years:

Kindergarten:	<input type="checkbox"/> special education classroom	<input type="checkbox"/> inclusion setting	<input type="checkbox"/> regular education
1 st grade:	<input type="checkbox"/> special education classroom	<input type="checkbox"/> inclusion setting	<input type="checkbox"/> regular education
2 nd grade:	<input type="checkbox"/> special education classroom	<input type="checkbox"/> inclusion setting	<input type="checkbox"/> regular education
3 rd grade:	<input type="checkbox"/> special education classroom	<input type="checkbox"/> inclusion setting	<input type="checkbox"/> regular education
4 th grade:	<input type="checkbox"/> special education classroom	<input type="checkbox"/> inclusion setting	<input type="checkbox"/> regular education
5 th grade:	<input type="checkbox"/> special education classroom	<input type="checkbox"/> inclusion setting	<input type="checkbox"/> regular education
6 th grade:	<input type="checkbox"/> special education classroom	<input type="checkbox"/> inclusion setting	<input type="checkbox"/> 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?			
Name of medication	Prescribed for:	(Helpful, Not Helpful)	Outcome Unusual reaction
1.			
2.			
3.			
Has the child previously been on medication?			
Name of medication	Prescribed for:	(Helpful, Not Helpful)	Outcome Unusual reaction
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.

Problem:	If yes, please check ✓	Please explain:
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?		
For girls: age at first menstrual period or none:		Regular? <input type="checkbox"/> Yes <input type="checkbox"/> 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: Diagnosis:	Report available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of testing:

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

EEG <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when: _____	where: _____	outcome: _____
CT <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when: _____	where: _____	outcome: _____
MRI <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when: _____	where: _____	outcome: _____

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

<input type="checkbox"/> African American	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American	<input type="checkbox"/> Other
<input type="checkbox"/> Asian American (Chinese, Japanese, Korean, Philipino)	<input type="checkbox"/> Latino/Latina	<input type="checkbox"/> Indian Subcontinent/ Middle Eastern	

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