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 and bring to the appointment along with any other medical, therapy or educational records that will be helpful as we get to know your child. 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
2nd 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:					

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

Were any chemical substances consumed during pregnancy? ☐ cigarettes ☐ alcohol ☐ marijuana ☐ other ___________		
Were there any concerns during pregnancy, labor, and delivery? If yes, please explain:		
How was your child delivered? ☐ vaginal birth ☐ 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:_____________ at12 months:_____________ at 18 months: ___________		
Please check all that apply:	☐ oxygen	☐ incubator
☐ NICU hospitalization # of days_________	☐ problems sucking/feeding	☐ antibiotic treatment
☐ jaundice ☐ biliruben lights or blankets	☐ infantile seizures	☐ 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 (no training wheels)		Pointing	
Independent Walking				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)				
☐ Speech/language therapy How often: ________	☐ Occupational therapy How often: ________	☐ Physical therapy How often:_______	☐ Consultation with "Interventionist" How often:__________	☐ 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) : ☐ special education ☐ inclusion setting ☐ 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): ☐ special education ☐ inclusion setting ☐ 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): ☐ special education ☐ inclusion setting ☐ 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:	☐ special education classroom	☐ inclusion setting	☐ regular education
1st grade:	☐ special education classroom	☐ inclusion setting	☐ regular education
2nd grade:	☐ special education classroom	☐ inclusion setting	☐ regular education
3rd grade:	☐ special education classroom	☐ inclusion setting	☐ regular education
4th grade:	☐ special education classroom	☐ inclusion setting	☐ regular education
5th grade:	☐ special education classroom	☐ inclusion setting	☐ regular education
6th 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? 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? ☐ 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: Diagnosis:	Report available? ☐ Yes ☐ No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? ☐ Yes ☐ No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? ☐ Yes ☐ No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? ☐ Yes ☐ No	Date of testing:
Name of Professional/Organization:	Purpose: Diagnosis:	Report available? ☐ Yes ☐ No	Date of testing:

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, Philipino)	☐ 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.