

## Developmental History Information

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### I. Student Information:

Student Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_  
Teacher: \_\_\_\_\_ School: \_\_\_\_\_  
Parent(s)/ Guardian: \_\_\_\_\_

### II. Family Information:

What are your child's strengths? \_\_\_\_\_  
\_\_\_\_\_

What concerns do you have for your child? \_\_\_\_\_  
\_\_\_\_\_

In what language did your child first learn to talk? \_\_\_\_\_

If English is 2<sup>nd</sup> language, how long has your child spoken English? \_\_\_\_\_

What language is primarily spoken at home? \_\_\_\_\_

Major Life Events Experienced by Your Child:

- Divorce of Parents       Death of a Close Family Member       Major Illness  
 Home Dislocation       Home Fire       Natural Disaster

Is there any other major life event experienced by your child that you think may have had an impact on your child? \_\_\_\_\_

### III. Medical History:

Child's physician \_\_\_\_\_ Physician phone # \_\_\_\_\_

Check any of the following complications that occurred during the pregnancy:

- Toxemia       Gestational Diabetes       Measles       RH incompatibility  
 Alcohol       Tobacco       Low Oxygen       Other: \_\_\_\_\_  
 Premature Birth-Weight: \_\_\_\_\_ Number of weeks in NICU: \_\_\_\_\_

Has this child ever had any serious illnesses, accidents, or head injuries?  Yes       No

If "yes", please explain: \_\_\_\_\_

Has this child ever experienced problems in the following areas?

- walking       temper tantrums       underweight/ overweight       unclear speech       failure to thrive  
 hearing       vision       sleep problems       eating problems       does not speak  
 fine motor skills (handwriting, tying shoes, etc)       Difficulty making friends  
 gross motor skills (running, riding bike, skip, etc)       Other

If any of the above are checked please specify: \_\_\_\_\_  
\_\_\_\_\_

Please indicate any illness this child has experienced:

- Measles       Asthma       Lead Exposure       Frequent Ear Infections       Gastro-intestinal problems  
 Diphtheria       Seizures       Rheumatic fever       Loss of consciousness       Any heart condition  
 Meningitis       Allergies       Verbal/ motor tics       Other, please describe: \_\_\_\_\_

Is this child presently on any medications? Yes No

If "yes", what kind? \_\_\_\_\_

Has your child ever had psychological counseling or therapy? Yes No

Complete the following if "Yes": Counselor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Has this child ever had a neurological exam? Yes No

If "Yes", please specify: \_\_\_\_\_

#### **IV. Educational Background:**

Did this child attend preschool? Yes No

If "Yes", where and for how long? \_\_\_\_\_

Have any relatives had difficulties similar to those this child is experiencing? Yes No

If "Yes", please explain: \_\_\_\_\_

Please indicate whether this child exhibits any of the following behavior:

Has a short attention span Has Fears Overreacts when faced with a problem

Unhappy much of the time Seems impulsive Requires a lot of attention

Enjoys active games Enjoys activities such as reading, drawing, writing, etc.

Needs more help with school work than others his/her age

Other: \_\_\_\_\_

Please indicate any of the following that this student has experienced in school:

Skipped a grade Disliked going to school Had frequent absences from school

Behavior problems Emotional difficulties Changed schools several times in one school year

Poor Grades Difficulty with Math Has been evaluated for special education

Been Retained Difficulty with Reading Difficulty with writing or spelling

Other: \_\_\_\_\_

#### **V. Social History:**

How does your child spend his/her free time? \_\_\_\_\_

How many close friends does your child have? 0-2 2-4 4 or more

Please indicate if your child is able to do the following [now or earlier in their development]:

Show good eye contact engage in pretend play Discuss a variety of interests

Initiate conversation initiate play Is able to adjust to changes in routine

I give permission for my child to be observed, as needed, by educational specialists (speech-language pathologists, school psychologists, hearing specialist, etc.)

Signature of person completing this form: \_\_\_\_\_

Relationship to the student: \_\_\_\_\_

Please return this form to: \_\_\_\_\_