DEVELOPMENTAL HISTORY

Patient's Name _____ Date _____

Date of Birth_____ Age_____ Grade _____

Sex: Female_____ Male_____ Patient's primary language_____

Name of person completing this form _____

Relationship to this child _____

Reason for evaluation or primary concerns you have regarding your child's development:

_____

_____

_____

_____

_____

What do you hope to learn from this neuropsychological/psycho-educational evaluation?

_____

_____

_____

_____

_____

FAMILY

Father's name _____ Age _____

Father's occupation _____

Highest grade completed _____

Mother's name _____ Age _____

Mother's occupation _____

Highest grade completed _____

Does this child have other parent(s)/stepparents? _____

If yes, please provide information _____

Name all persons living with the child:

_____

_____

_____

If your child does not live you with full time, please explain (e.g., half-time with mom; half-time with dad; mother has full custody; child does/does not see parent; legal guardian relationship):

_____

_____

_____

_____

_____

BIRTH AND DEVELOPMENT

Birth weight: _____lbs. _____oz. Born at _____weeks (e.g., 39 weeks)

Child's condition at birth _____

Mother's condition at birth _____

Described any complications that occurred during pregnancy/birth:

_____

_____

_____

_____

Development

At what age did this child first do the following? Please indicate year/month of age.

_____ Turn Over

_____ Sit Alone

_____ Crawl

_____ Stand Alone

_____ Walk Alone

_____ Understand First Words

_____ Speak First Words

_____ Speaks in Sentences

Problems feeding? _____

When was this child toilet trained? _____

Did bed-wetting occur after toilet training ? _____ If yes, until what age? _____

Did bed-soiling occur after toilet training ? _____ If yes, until what age? _____

Any medical reasons for bed-wetting/bed-soiling? _____

Has this child experienced any of the following problems? If yes, please describe.

Unclear speech No Yes _____

***Did child ever receive speech or language services? No Yes

If yes, please describe:_____

Eating problem No Yes _____

Sleep problem No Yes _____

Temper tantrums No Yes _____

Excessive crying No Yes _____

Failure to thrive No Yes _____

Underweight/overweight problem No Yes _____

Problems separating from parents No Yes _____

Difficulty learning to ride a bike No Yes _____

Difficulty learning to throw/catch No Yes _____

Difficulty with fine motor skills No Yes _____

Difficulty with large motor skills No Yes _____

Does your child play/enjoy sports No Yes _____

***Did child ever receive speech/language therapy, occupational or physical therapy services?
No Yes

If yes, please describe:_____

Medical History: *Please describe any serious illnesses or operations (e.g., ear infections, measles, chicken pox, meningitis, anemia, head injury, loss of consciousness, broken bones, high fever):*

_____

_____

_____

Hearing or vision problems? _____

Has your child ever had a head injury (with or without loss of consciousness)? No Yes

If yes, please explain: _____ _____

Sensory Issues: Does your child have difficulties with the following:

Food (textures, smell, limited variety of foods) _____

Tactile (clothing tags, fabrics, socks, shoes, clothing in general) _____

Auditory (loud noise, public toilets, crowds) _____

Visual (bright noise, spinning objects) _____

Medical Care

Child's physician _____

Date/reason of last visit _____

Has this child ever has a neurological, psychological, or psychiatric exam? No Yes

If yes, please indicate provider's name and reason for exam _____

Has your child seen or currently seeing a counselor/ therapist? No Yes _____

If yes, counselor's name _____

Current medications _____

Behavior, Temperament, Friendships, Recreation, and Interests

Please indicate whether this child exhibits any of the following behaviors.

Is easily overstimulated in play	No	Yes	Has a short attention span	No	Yes
Seems overly energetic in play	No	Yes	Seems impulsive	No	Yes
Lacks self-control	No	Yes	Overreacts when faced with a problem	No	Yes
Cannot calm down	No	Yes	Seems unhappy most of the time	No	Yes
Hides feelings	No	Yes	Seems uncomfortable meeting new people	No	Yes
Has fears	No	Yes	Requires a lot of parental attention	No	Yes

What activities does this child enjoy? _____

_____

Please indicate how this child relates to other children.

Has problems relating to or playing with other children No Yes

Fights frequently with playmates No Yes Has difficulty making friends No Yes

Briefly describe your child's friendships: _____

_____

What role does this child take in peer group games (for example, leader, follower, observer, indifferent, etc.)?_____

If you stated "leader," do others follow him/her?_____

Education History

Does or did this child attend preschool/daycare? No Yes At what age? _____

Any problems in preschool? No Yes If yes, describe _____

_____

Does or did this child attend kindergarten? No Yes All day _____ Half-day _____

Any problems in kindergarten? No Yes If yes, describe _____

_____

Schools(s) attended:

Kindergarten _____

First Grade_____

Second Grade _____

Third Grade _____

Fourth Grade _____

Fifth Grade _____

Sixth Grade _____

Seventh Grade _____

Eighth Grade _____

High School _____

Please indicate whether this child has had any of the following school experiences.

Has been retained or skipped a grade in school _____

Has changed schools for reasons other than normal academic progression _____

Has difficulty with reading _____

Has difficulty with writing _____

Has difficulty with math _____

Gets poor grades _____

Has been tested for Special Education _____

Currently received special education services or has a 504 plan_____

Do you have any concerns about the quality of this child's school or teachers? _____

Additional Academic Experiences _____

_____

_____

_____

_____

_____

_____

_____

_____