

**Developmental History**

Student: \_\_\_\_\_

Date: \_\_\_\_\_

Completed by: \_\_\_\_\_

Relationship to the child: \_\_\_\_\_

Please complete and return as soon as possible to: \_\_\_\_\_

**Family Information**

Does the child live with both biological parents? \_\_\_\_ If not, with whom does the child live? \_\_\_\_\_

Are there other adults in the home? \_\_\_\_

If so, please list: \_\_\_\_\_

Is the child adopted? \_\_\_\_ If yes, at what age? \_\_\_\_

Are this child's parents divorced or separated? \_\_\_\_ If so, how old was the child at the time this occurred? \_\_\_\_

Who has custody of the child? \_\_\_\_\_ Does the child see the other parent? \_\_\_\_\_

Has the child ever lived with anyone other than parents (foster care, temporary care, etc.) \_\_\_\_\_

Has anyone in the family had a problem with any of the following: (such as chronic disease or illness, alcoholism, drug addiction, imprisonment, mental illness, abuse, etc.) \_\_\_\_ If so please describe:

\_\_\_\_\_  
\_\_\_\_\_

Has anyone in the family (other than the child) been diagnosed with autism, a developmental disability or had learning problems? \_\_\_\_ If so, please describe:

\_\_\_\_\_

Have there been significant changes in the family? \_\_\_\_ if so, please describe \_\_\_\_\_

\_\_\_\_\_

Please list names of other children in the family. Indicate ages, whether the person lives with this child and the relationship of the child with this person.

Name	Age	Lives in same home as child		Relationship to Student (sister, brother, etc)
_____	_____	yes	no	_____
_____	_____	yes	no	_____
_____	_____	yes	no	_____
_____	_____	yes	no	_____
_____	_____	yes	no	_____
_____	_____	yes	no	_____
_____	_____	yes	no	_____

**Prenatal/Birth History**

Were there complications during pregnancy? \_\_\_\_\_

Mother's age at time of this child's birth? \_\_\_\_ Child's Birth Weight \_\_\_\_\_

Was the birth unusual in any way? (medical problems?) \_\_\_\_\_

Was the child premature? \_\_\_\_ If so, how early? \_\_\_\_ Was the child overdue? \_\_\_\_ If so, how late? \_\_\_\_

**Early Developmental History**

	No	Yes	Comments
1. Did the child babble by 10-12 mos.?			
2. Did the child often make noises to get your attention?			
3. Did the child use gestures by 10-12 mos.? (e.g. wave or point)			
4. Did the child use single words by 16 mos.?			
5. Did the child use 2 word phrases by 24 mos. (that don't involve repeating or imitating)?			
6. Did the child increasingly respond to his/her name from 6 mos. to 12 mos.?			
7. Did the child frequently make eye contact with caregiver?			
8. Did the child seem interested in others?			
9. Did the child seem to hear when others talk to him/her?			
10. Did the child reach out when others tried to pick the child up?			
11. Did the child make smiles or other joyful expressions by 6 mos.?			
12. Did the child use pointing to express interests or "show" objects to you or someone else?			
13. Did the child often engage in back and forth sharing of smiles, sounds or facial expressions?			
14. Did the child follow objects in their line of sight?			

	Yes	No	Comments
1. Has there been any significant loss of language or other skills?			
2. Has there been significant difficulty with learning?			

What skills were "lost" or what learning difficulties have been seen:

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Have there been any delays in the development of speech/language? Yes No; if so, describe: \_\_\_\_\_

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Have there been any delays in the development of fine or gross motor skills? Yes No; if so, describe: \_\_\_\_\_

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Have there been any delays in the development of socialization skills (e.g. making friends, getting along with others)? Yes No; if so, describe: \_\_\_\_\_

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Have there been any delays in the development of self-help skills (e.g., dressing, toileting, feeding, personal safety, helping others)? Yes No; if so, describe: \_\_\_\_\_

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**Early and current characteristics**

Please check any of the characteristics below that describes this child during the early years of development and those that describe your child currently. Please describe the behaviors you have checked on the lines that follow.

Early    Currently

- Shy or timid \_\_\_\_\_
- Affectionate \_\_\_\_\_
- Temper Tantrums \_\_\_\_\_
- Daredevil Behaviors \_\_\_\_\_
- Overly active, restless \_\_\_\_\_
- Less active than other children \_\_\_\_\_
- Interacts well with other children \_\_\_\_\_
- Interacts well with adults \_\_\_\_\_
- Has few or no friends \_\_\_\_\_
- Seems immature for age \_\_\_\_\_
- Has trouble paying attention \_\_\_\_\_
- Cries more easily than others of same age \_\_\_\_\_
- Wants to be left alone \_\_\_\_\_
- Unusual fears \_\_\_\_\_
- Rocking or head bumping \_\_\_\_\_

**Medical History**

Are there any vision or hearing issues/concerns? \_\_\_\_ If yes, please describe

\_\_\_\_\_

Does the child have any physical problems? \_\_\_\_ If yes, explain. \_\_\_\_\_

Has the child had seizures? \_\_\_\_ How old was the child when this happened? \_\_\_\_ Please describe: \_\_\_\_\_

Has the child been in counseling? \_\_\_\_ If so, when and with whom: \_\_\_\_\_

Does the child have a history of ear infections? \_\_\_\_ If yes, describe the age and any medical interventions (e.g., tubes, etc.)

\_\_\_\_\_

Has the child ever had a head injury that required medical treatment? \_\_\_\_ If so, please describe the injury:

\_\_\_\_\_

Has the child ever been hospitalized? .?

Has the child ever been identified, by a medical provider, as Hyperactive or as having Attention Deficit Disorder? \_\_\_\_ If so, at what age? \_\_\_\_\_

Is he/she currently on medication for this disorder? \_\_\_\_ If so, what medication \_\_\_\_\_

Is your child currently on any medication or being treated for any other illness or disorder? \_\_\_\_ If yes, describe the illness/disorder and the medication \_\_\_\_\_

Has your child ever been diagnosed as having a Developmental Disorder (e.g., Developmental Delay, Autism, Intellectual Disability, Learning Disability, Speech or Communication Disability)? Yes No

If so, what was the diagnosis, when did this happen and who made it?

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Has your child ever been diagnosed as having a Mental health, Social-Emotional or Behavioral problem (e.g., Oppositional Defiant, Disorder, Conduct Disorder, Adjustment Disorder, Mood Disorder (ex. Depression, Bipolar Disorder), Thought Disorder, Anxiety Disorder, Schizophrenia)? Yes No

If so, what was the diagnosis, when did this happen and who made it?

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Has the child experienced significant stress, extremely abusive behaviors from others or traumatic events? Yes No

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**Educational Issues**

*If in school*, what does your child like about school?

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What does your child dislike about school?

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What do you feel are your child's major problems in school?

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What do you believe are your child's strengths or best qualities?

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Has your child had significant difficulties with any of the following:

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|--|---|
| Listening:_____                        | Following directions_____                         |
| Paying attention during lessons_____   | Participating in discussions_____                 |
| Remembering what has been learned_____ | Remaining on-task_____                            |
| Following school/class rules_____      | Completing assignments/work in class_____         |
| Studying _____                         | Doing homework _____                              |
| Organizing work materials_____         | Keeping up with assignments_____                  |
| Respecting others_____                 | Working/playing cooperatively_____                |
| Test taking:_____                      | Socializing appropriately with peers, adults_____ |
| Seeking assistance when needed_____    | Speaking clearly_____                             |

What did you first notice that made you think your child might have problems?

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Is there anything else that we need to know about this child to assist the schools in providing appropriate assistance?