



Developmental History Information

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 2nd 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 Premature Birth
 Other _____

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 Mumps Asthma 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

Signature of person completing this form: _____

Relationship to the student: _____

Please return this form to: _____