Children's Neuropsychological Services, PLLC

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Developmental History Form

Personal Information:

Today's date: _____

Child's name: _____

Child's date of birth: _____ Age: _____ Grade: _____

Child's sex at birth: _____ Gender: _____ Preferred Pronouns: _____

Person completing this form: _____

Relationship to child: _____

Referral Information:

Who referred this child for evaluation? _____

Child's primary care physician: _____Phone: _____

Physician's Address: _____

Street City/Town State Zip Code

What are your main concerns about this child?

At what age was this child's problem first noted? By whom?

What do you hope to get out of this evaluation?

History of Treatment:

Please list all of the diagnoses the child currently has. Include learning disorders (reading, writing or math), neurodevelopmental disorders (e.g., ADHD, autism, tics, intellectual disability etc.), neurologic conditions (e.g., epilepsy, brain injury etc.), and psychiatric conditions (e.g., anxiety disorder, depression etc.). Please be specific.

Date Diagnosed _____ Diagnosis _____

Date Diagnosed _____ Diagnosis _____

Date Diagnosed _____ Diagnosis _____

Date Diagnosed _____ Diagnosis _____

Please list all prior hospitalizations for any reason including illness, injury, surgery, psychiatric.

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

List all the medical, developmental, psychological/psychiatric and educational specialists this child has seen for evaluation or treatment.

Specialist name and title _____ Reason _____

Specialist name and title _____ Reason _____

Specialist name and title _____ Reason _____

Specialist name and title _____ Reason _____

Medical History:

Age of mother at time of delivery: _____ Length of pregnancy: _____ weeks

Any complications experienced by mother or baby ***during pregnancy***? _____ Please describe.

What medications did the mother take during pregnancy?

Did the mother drink alcohol during pregnancy? _____ If yes, how much? _____

Did the mother smoke cigarettes during pregnancy? _____ If yes, how many per day? _____

Did the mother use any other drugs during pregnancy? _____

Describe any complications **during delivery** (e.g., fetal distress, insufficient oxygen, meconium aspiration, jaundice):

Baby was delivered: ___ Vaginally ___ By C-section Baby weighed: _____

Did the baby have any respiratory difficulties or other complications immediately or soon after birth? _____

Please describe. _____

Did the baby require treatment in the Neonatal Intensive Care Unit (NICU)? _____ How long? _____

How soon after birth was the baby discharged from the hospital? _____

Did the child have any medical problems in the first year of life? _____

Please describe. _____

List the names and doses of ***all*** the medications this child is taking **at this time**. Also, provide the reason the medication was prescribed.

Has this child had any significant medical conditions? (Put an X on all that apply,)

____ Febrile seizures	____ Loss of consciousness	____ Head injury
____ Lead poisoning	____ Epilepsy	____ Heart condition
____ Diabetes	____ Meningitis	____ Asthma
____ Allergies	____ Other _____	

Has this child had an MRI or other imaging or the brain? _____

Were there problems with multiple ear infections or fluid? _____ Were PE tubes placed? _____

Any problems with hearing? _____ Please describe_____

Any problems with vision? _____ Does this child wear glasses? _____ For? _____

Are there any problems with appetite? _____ Please describe_____

How many hours of sleep does this child receive on most nights? _____

Has this child had difficulty with any of the following sleep problems? (Put an X on all that apply)

____ falling asleep ____ staying asleep ____ difficulty waking

____ night terrors ____ nightmares ____ sleep walking or talking

____ sleeping alone ____ Other _____

Has this child ever ***lost*** any developmental skills (e.g., stopped walking, stopped talking)? _____

Please describe

Motor Development:

Did this child experience any delays in early gross motor development (such as rolling over, crawling, walking)? _____

Has this child ever received physical therapy? _____ If yes from age _____ to age _____

Did this child experience any delays in fine motor skills (e.g., utensils, buttons, tying shoes, handwriting)?

_____

Has this child ever received occupational therapy? _____ If yes from age _____ to age _____

Describe any current concerns about motor skills: _____

What is your child's hand preference: _____

Does this child display any repetitive or unusual motor behaviors? (Put an X on all that apply)

____ Hand Flapping	____ Rocking	____ Eye rolling
____ Head flicking	____ Facial grimacing	____ Eye rubbing
____ Hand rubbing	____ Clicking/clucking sounds	____ Throat clearing
____ Pacing	____ Picking	____ Other _____

Does this child have exceedingly strong negative reactions to certain sensory experiences? (Put an X on all that apply)

____ Food textures	____ Feel of clothing	____ Textures (e.g., playdough)
____ Human touch/hugs	____ Noise	____ Light
____ Tastes	____ Voices	____ Other _____

Does this child show strong sensory interests, such as preoccupations with smelling or feeling things? _____

Please describe. _____

Language Development:

Did this child have any delays in early speech/language development (e.g., babbling, imitating sounds/words, speaking first words or putting words together to make sentences)? _____ Please describe.

_____

Has this child ever received speech and language therapy? _____ If yes, from age _____ to _____

Describe any ***current*** language problems. _____

Temperament and Social Development:

Did this child's early social and play skill development seem typical (for example, looking at caregivers, responding positively to caregiver interactions, enjoying early games like Peek-a-Boo)? _____

Please describe _____

As this child got older, did he/she engage in imitative play and fantasy/imaginative play (such as playing house, superheroes, cops and robbers, etc.) *with* his/her peers? _____

Please describe _____

This child gets along best with children who are _____ younger _____ same age _____older _____ adult

Does this child have difficulty making or keeping friends or have trouble getting along with other children his/her age? _____ Please describe _____

Does this child seem to understand social cues well (e.g., when others are angry or upset)? _____

Please describe _____

Describe any other current social problems, if any:

Interests and Play/Leisure Activities:

In what activities does this child engage in his/her free time?

Does this child have interests that are unusual for his/her age/peer group? _____ Please describe.

_____

Are there excessive interests/preoccupations with certain topics/activities? _____ Please describe.

_____

Does this child engage in any repetitive or ritualized activities (e.g., lining up toys, replaying same play scheme over and over)? _____

Attention and Activity Level:

Has this child been evaluated for attention deficit hyperactivity disorder? _____

If yes, Doctor's name: _____

This child has problems with the following:

____ Short attention span	____ Easily distracted	____ Easily sidetracked
____ Forgetful	____ Disorganized	____ Following directions
____ Loses things	____ Multitasking	____ Finishing tasks

This child has problems with the following:

____ Sitting still	____ Playing calmly/quietly	____ Fidgety
____ Excessive Energy	____ Difficulty Sleeping	____ Movement/talking in sleep
____ Lacks self-control	____ Acts without thinking/impulsive	

Behavior:

Describe the positive aspects of this child's personality/behavior.

Does this child have difficulty following rules, or is he/she argumentative? _____ Please describe

_____

Is this child verbally or physically aggressive? _____

Does this child get "in trouble" in school? _____

Are this child's problems the same at home and at school?_____

Describe any other concerns about this child's behavior.

What type of discipline has been effective with this child? _____

Do you feel that you and your spouse/partner/other caregivers are "on the same page" regarding discipline and child rearing? _____

Have you or your immediate family members received any parenting training/therapy? _____

Therapist name and title _____ Reason _____

Was the treatment effective? _____

Psychological:

Does this child exhibit excessive fear, anxiety or worry a lot? _____ Please describe.

Does this child engage in any routines/rituals designed to reduce anxiety (e.g., handwashing, following rigid sequences, counting)? _____ Please describe.

Has this child ever had a panic attack? _____ Please describe and note how often they occur.

Describe this child's typical mood (happy, sad, irritable) and any problems they have controlling emotions.

Has this child ever expressed suicidal thoughts? _____

Has this child ever engaged in self-injurious behavior? _____

Does this child have a history of trauma? _____

Is there concern about alcohol or drug use? _____

Academics:

Name of Child's current school: _____

District:_____

Placement: _____regular classes _____special classroom ____co-taught

_____ resource _____combination _____other _____

Any grades repeated or skipped? _____

What are this child's academic strengths? _____

This child's teachers report problems in: (put an X on all that apply)

____ Reading ____ Writing

____ Math ____ Behavior

____ Social adjustment ____ Organization or study skill

____ Motivation _____ Other _____

Please list the names of each school that this child has attended.

_____ grade(s) _____

_____ grade(s) _____

_____ grade(s) _____

_____ grade(s) _____

_____ grade(s) _____

_____ grade(s) _____

Goes this child have or receive any of the following? (Put an X on all that apply).

_____IEP Grades _____ Classification(s)_____

_____504 Plan Reason_____

_____ RTI Reason _____

_____MTSS Reason_____

What special services, accommodations and modifications does he/she currently receive? (Put an X on all that apply)

_____ Resource room	_____ Reading Intervention	_____ Math Intervention
_____ Occupational Therapy	_____ Physical Therapy	_____ Speech & Lang. Therapy
_____ Aide	_____ Reader	_____ Scribe
_____ Testing Modifications	_____ Social Skills	_____ Counseling
_____ Study skills	_____ Adaptive PE	_____ other _____

Has your child received outside tutoring? If yes, when and for what subject(s)?

Family History:

Please provide the following about primary caregivers, such as mother, father, guardian (This section continues next page).

Name (**1st** caregiver): _____ Relationship to child: _____

Address: _____

Street City/Town State Zip Code

Home phone: _____ Cell phone: _____

Age: _____ Highest grade (degree) completed in school: _____

Occupation: _____ _____ Full time _____Part time

Is this person biologically related? If no, please explain: _____

Name (**2nd** caregiver): _____ Relationship to child: _____

Address: _____

Street City/Town State Zip Code

Home phone: _____ Cell phone: _____

Age: _____ Highest grade (degree) completed in school: _____

Occupation: _____ _____ Full time _____Part time

Is this person biologically related? If no, please explain: _____

If this child was adopted, what is the date of the adoption? _____

Parents/Caregivers are:

_____ Married _____Divorced (date:_____) _____Separated (date:_____)

Please list all brothers and sisters, including full, half and stepsiblings.

			Relationship to Child		
Name:_____	Age:_____	Sex:_____	_____Full	_____Half	_____Step
Name:_____	Age:_____	Sex:_____	_____Full	_____Half	_____Step
Name:_____	Age:_____	Sex:_____	_____Full	_____Half	_____Step
Name:_____	Age:_____	Sex:_____	_____Full	_____Half	_____Step
Name:_____	Age:_____	Sex:_____	_____Full	_____Half	_____Step

Please list all people living with this child and indicate their relationship to the child.

Are there stressors or pressures on the family at this time that you think are negatively affecting the child? (e.g., family conflict, health, finances, cultural factors, race or other issues)

Do/did any **biological** family members (parents, siblings, grandparents, aunts, uncles) have any of the following conditions? (Put an X on all that apply.)

____ dyslexia	_____learning disorder	_____ADHD/ADD	_____autism spectrum
____ epilepsy	_____brain condition	_____Chromosome defect	_____genetic disorder
____ tics	_____anxiety	_____depression	____other _____

Please discuss any condition that is relevant to the child.

Other Information

Is this evaluation going to be used in court, an impartial hearing or other legal proceeding? _____

Please describe._____

Please share any additional information that you believe will be helpful for this evaluation: