*Developmental History Form*

**Date Form Completed**: \_\_\_\_\_\_\_\_\_\_\_\_\_ **Person Completing the Form**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name and relationship to client*

**Client’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex**: M / F **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

**Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASONS FOR EVALUATION**

Please list the reason(s) the client is being referred for the evaluation:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

When did these problems begin?

What are you goals for this evaluation?

Has the client ever received the diagnosis of an autism spectrum disorder?  **Yes**  **No**

If yes, in what month & year \_\_\_\_\_\_\_\_\_ and by whom \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY INFORMATION**

**Mother/Guardian Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full-time  Part-time

**Father/Guardian Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full-time  Part-time

**Parents are: Child lives with:**

Married  Biological Mother

Unmarried, Living Together  Biological Father

Never Married, Living Together  Step-parent

Separated  Adoptive Parent (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Divorced  Grandparent

Mother Deceased  Legal Guardian (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father Deceased  Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sibling Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of sibling** | **Sex** | **Age** | **Different**  **Father?** | **Different**  **Mother?** | **List any health/behavior/ learning problems** | **Lives with child?** |
|  |  |  | **Y** **N** | **Y** **N** |  | **Y** **N** |
|  |  |  | **Y** **N** | **Y** **N** |  | **Y** **N** |
|  |  |  | **Y** **N** | **Y** **N** |  | **Y** **N** |
|  |  |  | **Y** **N** | **Y** **N** |  | **Y** **N** |
|  |  |  | **Y** **N** | **Y** **N** |  | **Y** **N** |

How well does your child get along with his/her siblings?

Very Well  Good  Average  Fair  Poor

Is English the client’s primary speaking language:  Yes  No

If no, what is the client’s primary language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the client’s secondary language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child Care and Discipline**

Who is primarily responsible for the client’s care?  Mother  Father  Both  Other:\_\_\_\_\_\_\_\_\_\_\_

Who is mainly in charge of discipline in the home?  Mother  Father  Both  Other:\_\_\_\_\_\_\_\_\_

*Please describe discipline techniques:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**FAMILY PSYCHIATRIC HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition/Disorder** | **Mother** | **Father** | **Brother** | **Sister** | **Grandparent** | **Aunt/**  **Uncle** | **Other Close Relatives** |
| Alcoholism |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |
| ADHD/ADD |  |  |  |  |  |  |  |
| Autism Spectrum Disorder |  |  |  |  |  |  |  |
| Bipolar Disorder |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Epilepsy/Seizure Disorder |  |  |  |  |  |  |  |
| Genetic Condition |  |  |  |  |  |  |  |
| Hospitalized for Emotional Problems |  |  |  |  |  |  |  |
| Intellectual disability |  |  |  |  |  |  |  |
| Jail Time/Incarceration |  |  |  |  |  |  |  |
| Language disorder |  |  |  |  |  |  |  |
| Learning Disability |  |  |  |  |  |  |  |
| Motor or Vocal Tics |  |  |  |  |  |  |  |
| Psychosis or Schizophrenia |  |  |  |  |  |  |  |
| Special Education |  |  |  |  |  |  |  |
| Substance Abuse |  |  |  |  |  |  |  |
| Suicidal Ideation/Attempt |  |  |  |  |  |  |  |

**PREGNANCY AND BIRTH HISTORY**

Parental ages when client was born: Mom \_\_\_\_\_\_\_\_\_\_\_ Dad \_\_\_\_\_\_\_\_\_\_\_

Was this pregnancy full term?  **Yes**  **No** If not, how many weeks before or after the expected due date

was the baby born? \_\_\_\_\_ weeks  **BEFORE**  **AFTER** due date

Pregnancy number: 1st, 2nd, 3rd, 4th, other \_\_\_\_ Totals: # of pregnancies \_\_\_\_\_\_ # of miscarriages \_\_\_\_\_\_

Was this a multiple birth?  **Yes**  **No**  **UK** ; if yes: **Twins** **Triplets** **Quadruplets**

Were the babies identical? **Yes**  **No**  **UK** (unknown)

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s health during pregnancy:**

No health problems during pregnancy  Health during pregnancy not known

Poor weight gain  Severe nausea { with dehydration}

Seizures  Infections (Flu, measles, CMV)

High blood pressure  Eclampsia/Toxemia

Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Rh (blood group) incompatibility

List medications taken during this pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the mother consume more than 2 glasses of alcohol a day during this pregnancy?  Yes  No

Did the mother smoke during pregnancy?  Yes  No

Did the mother consume illegal substances during the pregnancy?  Yes  No

**Labor and Delivery**:

No problems during labor and delivery  Not known

Please note whether any problems occurred during labor or delivery ( all that apply):

Excessive bleeding  Forceps Used

Meconium staining  Umbilical cord around baby’s neck

Fever or infection of mother  Breathing difficulties of child

Placenta previa or abruption  Placenta (bag of water) broke more than 1 day before delivery

Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Baby was born   head first   breech (feet first)  vaginal   Cesarean (Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight lbs oz Length in. (if known) Head circumference \_\_\_\_\_\_ in. (if known) Apgar Scores (if known): \_\_\_\_\_\_ at 1 min \_\_\_\_\_\_ at 5 min

**Newborn period:**

Was the child healthy as a newborn?  **Yes  No** If not, please describe the problems and treatment:

Was the child born with any birth defects?  Yes  No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the child require treatment in a newborn intensive care unit?  Yes (for \_\_\_\_\_\_\_\_\_ days)  No

Did the baby require any special care immediately after birth?  Yes  No

If yes, √ all that apply

Breathing problems (requiring  oxygen  ventilator (with a tube in windpipe)

Placement in an incubator

Blood transfusions

Significant muscle weakness or paralysis

Poor muscle tone

Seizures

Feeding difficulties

Excessive sensitivity to noise/stimulation

Jaundice treated with lights

Infection

Surgery (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History**

**Social Development**

Did you notice any delays in the client’s social development?  Yes  No

As an infant, did the client:

Enjoying cuddling?  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tend to be fussy/irritable?  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Make appropriate eye contact?  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respond to his/her name?  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the first four years of life, were any special problems noted in the following areas?

*If yes, please describe below:*

Temper Tantrums  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Separating from parents  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Excessive crying  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Playing with other children  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Speech and Language Development**

Did you notice any delays in the client’s language development?  Yes  No

*If yes, please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the following milestones develop on time? Please specify age (year/month).

Show interest in sound *(by 3 months)*   Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Babbling *(by 4 to 6 months)*   Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Understanding words *(by 6-11 months)*  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speaking first words *(by 12 months)*  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speaking in short phrases *(by 24 months)*  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Motor Development**

Did you notice any delays in the client’s motor development?  Yes  No

*If yes, please specify:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the following milestones develop on time? *Please specify age (year/month).*

Turn over (by 6 months)  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sit alone (by 9-12 months)  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crawl (by 9-12months)  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stand alone (by 9-12 months)  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walk alone (by 12-18 months)  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walk upstairs (by 36 months)  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walk downstairs (by 48 months)  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Running  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which hand does the client use for writing or drawing?  Right  Left Both

Eating?  Right  Left Both

Throwing? Right  Left Both

**Daily Living**

When was the client toilet trained? Days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nights:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did bed-wetting occur after toilet training?  Yes  No If yes, until what age? \_\_\_\_\_\_\_\_\_\_\_\_\_

Did bed-soiling occur after toilet training?  Yes  No If yes, until what age? \_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have difficulty with sensory processing?

If yes, please describe below:

Tolerating Food Textures  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gagging or Vomiting  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tolerating Clothing  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tolerating Touch from Others  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Not Notice Pain  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant LOSS of an acquired skill or skills (not just a delay)?** For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Speech / language  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Problem solving  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Motor coordination  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Bladder/bowel control  Age of loss: \_\_\_\_\_\_ months; Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**MEDICAL HISTORY**

No serious illnesses or injuries in the **past**  No serious illnesses or injuries **now**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** | **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** |
|  |  | **Serious Injuries** |  |  |  |  | **Lung/breathing Problems** |  |  |
|  |  | Serious head injury |  |  |  |  | Asthma |  |  |
|  |  | Other serious injury |  |  |  |  | Pneumonia |  |  |
|  |  | Loss of consciousness |  |  |  |  | Apnea or irregular breathing |  |  |
|  |  | **Sleep Problems** |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | **Neurological Problems** |  |  |  |  | **Stomach/bowel Problems** |  |  |
|  |  | Birth abnormality |  |  |  |  | Swallowing problems |  |  |
|  |  | Seizures (any type) |  |  |  |  | Gastroesphageal reflux |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Chronic abdominal pain |  |  |
|  |  | **Vision Problem** |  |  |  |  | Chronic diarrhea |  |  |
|  |  | Vision problems at birth |  |  |  |  | Chronic constipation |  |  |
|  |  | Requires glasses/contacts |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | **Kidney/Bladder Problems** |  |  |
|  |  | **Hearing** **Problem** |  |  |  |  | Abnormalities at birth |  |  |
|  |  | Hearing problems at birth |  |  |  |  | Kidney/bladder infections |  |  |
|  |  | Deafness |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | Chronic ear infections |  |  |  |  | **Muscle/bone/joint) Problems** |  |  |
|  |  | Ear tubes |  |  |  |  | Abnormalities at birth |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Scoliosis or spinal curvature |  |  |
| **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** | **Date** | Age | **Diagnosis/Illness** | **Past** | **Now** |
|  |  | **Dental Problem** |  |  |  |  | **Circulatory Problem** |  |  |
|  |  | Abnormally shaped/ missing teeth |  |  |  |  | Anemia |  |  |
|  |  | Extractions/cavities |  |  |  |  | Sickle cell disease |  |  |
|  |  | Dental braces |  |  |  |  | Chronic low platelet count |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Bleeding /bruising problem |  |  |
|  |  | **Skin Problem** |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | Eczema |  |  |  |  | **Hormone Problem** |  |  |
|  |  | Ash leaf patches |  |  |  |  | Sugar diabetes |  |  |
|  |  | Café-au-lait spots |  |  |  |  | Early puberty |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Late or incomplete puberty |  |  |
|  |  | **Growth Problem** |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  | Failure to gain weight |  |  |  |  | **Mental Health problem** |  |  |
|  |  | Obesity |  |  |  |  | ADHD |  |  |
|  |  | Short stature |  |  |  |  | Oppositional defiant disorder |  |  |
|  |  | Tall stature |  |  |  |  | Anxiety disorder |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Obsessive-compulsive disorder |  |  |
|  |  | **Heart Problem** |  |  |  |  | Depression |  |  |
|  |  | Heart abnormalities at birth |  |  |  |  | Bipolar disorder (manic-depressive) |  |  |
|  |  | Heart surgery |  |  |  |  | Schizophrenia |  |  |
|  |  | Heart rhythm abnormalities |  |  |  |  | Tic disorder (e.g., Tourette) |  |  |
|  |  | High blood pressure |  |  |  |  | Intellectual disability |  |  |
|  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Eating disorder (e.g.,  anorexia) |  |  |
|  |  |  |  |  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

I have confirmed with my child’s Primary Care MD that his/her immunizations are up to date.  **Yes**  **No**

**If no, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specialized neurological or genetic tests:**

No neurological or genetic testing has been done

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ** If done** | **Date (if known)**  **Month/Year** | **Test** | **Normal**  **Result** | **Abnormal**  **Result** | **Unknown**  **Result** |
|  |  | EEG (brain wave test) |  |  |  |
|  |  | CT scan |  |  |  |
|  |  | MRI scan |  |  |  |
|  |  | PET/SPECT/ scan  roscopy |  |  |  |
|  |  | Other scan (specify): |  |  |  |
|  |  | Chromosomal microarray |  |  |  |
|  |  | Chromosomal analysis (karyotype) |  |  |  |
|  |  | DNA testing for fragile X syndrome |  |  |  |
|  |  | Other genetic test: |  |  |  |

**List all hospitalizations and surgeries for the client, include overnight stays (medical or behavioral)**

No past hospitalizations or surgery

|  |  |  |
| --- | --- | --- |
| **Reason for hospitalization/surgery** | **Age** | **Length of stay** |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergies** (to medications, foods, environmental antigens, etc.)

No past or current allergies

|  |  |
| --- | --- |
| **Source (medication, food, etc.)** | **Nature of reaction (hives, trouble breathing, etc.)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Current Medications**

No medications taken **now**  Medications are being taken now, but the names are not known

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Age at start** | **Reason for medication** | **Improved** | |
|  |  |  |  | **Y** | **N** |
|  |  |  |  | **Y** | **N** |
|  |  |  |  | **Y** | **N** |
|  |  |  |  | **Y** | **N** |
|  |  |  |  | **Y** | **N** |
|  |  |  |  | **Y** | **N** |

**Name of person prescribing the medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RESOURCES**: Please indicate resources/services being received **now**

No resources/services are being received now

Early Intervention Services (Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Speech/Language therapy  Psychiatry services  Behavioral therapy  Group therapy  Physical therapy

Occupational therapy  Case management  Wraparound services (WRAP)  Mobile Therapist (MT)

Behavior Specialist Consultant (BSC)  Therapeutic Staff Support (TSS)  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATIONAL HISTORY**

School name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Grade in school: (ever repeat a grade? Yes / No)Teacher (or best contact): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the client currently on a formal education plan in school?  **Yes**  **No**

If yes, please check: □ IEP □ 504 Plan

What best describes the client’s current educational program?

Full time in a regular class

Time split between regular and special education classes

Special education class

Aide/Paraprofessional or extra help

Specialized school

Home schooled

**Please indicate the educational program in which the client participated during his/her school\* years:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **School Year** | **Type of School**  Regular**\*** Special | | **Type of Class**  Regular\*Special\* | | *Any Special Services*  Yes No Type | | |
| 3-5 preschool |  |  |  |  |  |  |  |
| Kindergarten |  |  |  |  |  |  |  |
| 1st |  |  |  |  |  |  |  |
| 2nd |  |  |  |  |  |  |  |
| 3rd |  |  |  |  |  |  |  |
| 4th |  |  |  |  |  |  |  |
| 5th |  |  |  |  |  |  |  |
| 6th |  |  |  |  |  |  |  |
| 7th |  |  |  |  |  |  |  |
| 8th |  |  |  |  |  |  |  |
| 9th |  |  |  |  |  |  |  |
| 10th |  |  |  |  |  |  |  |
| 11th |  |  |  |  |  |  |  |
| 12th |  |  |  |  |  |  |  |

**\* REGULAR school applies to public or private schools for children without disabilities.**

**SPECIAL school applies to any schools intended for children with disabilities**

**SOCIAL AND BEHAVIORAL FUNCTIONING**

**Peer Relationships**

Please indicate how the client relates to peers:

Has problems relating to other children

Has difficulty making friends

Fights frequently with peers

Prefers playing with younger children

Prefers playing with older children

Prefers to play alone

Has a best friend

What role does the client take in peer groups?  Leader  Follower  Some of Each

How many friends does the client have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recreational Interests**

What does the client enjoy?

Sports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the client’s personal strengths?

What do you enjoy most about the client?

What are your hopes for the client’s future?