*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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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/ scanroscopy | [ ]  | [ ]  | [ ]  |
| [ ]  |   | 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?