DATE: _____

DEVELOPMENTAL HISTORY FORM

Educationally Relevant Medical, Development, and Family Information
This information may be included in a confidential psycho-educational evaluation report.

Name of Student _____Date of Birth _____ Location of Birth _____
Information Provided by: _____ Relationship _____

Family Information

Does child live with both biological parents? In not, with whom does your child live? _____
Is child adopted? ____ If yes, at what age? _____
Are this child's parents divorced or separated? ____ If so, how old was your child at the time this occurred? _____ Does your child see other parent? _____ If yes, how often? _____
Has your child ever lived with anyone other than parents (foster care, temporary care, etc.) _____
If yes, describe who and for what length of time. _____
List all other children in the family. Please indicate whether each child lives with the family with an X.

_____ M F Age Lives with Family ___ _____ M F Age Lives with Family
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_____ M F Age Lives with Family ___ _____ M F Age Lives with Family
_____ M F Age Lives with Family ___ _____ M F Age Lives with Family

Does anyone else live with the family (friends, uncles, cousins, grandparents, etc.? Please list all other members of the household and the relationship to your child.

_____
_____

Has either parent or any other child in the family had a problem that may have had a significant effect on this child (such as chronic major illness, mental illness, alcoholism, drug addiction, unemployment, imprisonment, child or spousal abuse, etc. _____ If yes, please describe: _____

Prenatal History

While pregnant with your child, was the mother under the care of a medical provider? ____ At what date?_____
Did the mother have any illness during pregnancy? (e.g. diabetes, toxemia, mental illness, etc.) _____
If yes, describe the illness? _____ Did the mother use tobacco products during pregnancy? _____ Did the mother use alcohol during the pregnance? _____ If so, describe the alcohol use: _____
Did the mother use illegal drugs during the pregnancy? _____ If yes describe the drug use: _____ _____ Was the prenatal period unusual in any way? _____ If yes, please describe any unusual situation or complication: _____

Birth History

Mother's age at time of this child's birth? _____ Child's Birth Weight _____ Birth Length _____
Was the birth unusual in any way? _____ If so, please describe _____
Was your child premature? _____ If so how early? _____ Was your child overdue? _____
If so, how late? _____ Was the birth C-Section? _____ If yes, please describe any complications that led to or resulted from the C-Section _____

Developmental History

As well as you can remember, please list the approximate age in years and months that your child was able to perform each skill below independently.

First steps _____ Bowel Trained _____ Drank from a cup _____
First words _____ Dry during day _____ Fed self _____
Spoke in sentences _____ Dry at night _____ Dressed self _____
Would you describe development as generally (circle the best descriptor) Early Typical Late

Vision/Hearing

Has your child's vision been tested ? _____ If so, when? _____ Were the results normal? _____
If not, please list the concerns. _____
Has your child's hearing been tested? _____ If so, when? _____ Were the results normal? _____
If not, please list the concerns. _____

Please turn to the back side

Socialization

Please check any of the characteristics below that describes this child during the infant or 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 _____
□	□	Bedwetting _____
□	□	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 _____
□	□	Wants to be left alone _____
□	□	Other _____

Physical or Medical

Does your child have any current physical problems? _____ If yes, explain. _____
Does your child have any allergies? _____ If yes, explain. _____
Has your child had seizures? _____ If yes, describe the severity and age at which the problems occurred: _____
Does your child have a history of ear infections? _____ If yes, describe the age and any medical interventions (e.g., tubes, etc.) _____
Has your child ever had a head injury that required medical treatment? _____ If so, please describe the injury and the treatment: _____ If your child was hospitalized, where and for what length of time _____
Has your child ever been hospitalized for illness or had surgery? _____ If yes, describe (include the reason and date of hospitalization). _____
Has your child ever been identified, by a medical provider, as hyperactive or attention deficit disorder? _____
If so, at what age? _____ Is he or she currently on medication for this disorder? _____ If so, what medication and level of dosage? _____ 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 _____

School History

Did your child attend preschool? _____ Did your child attend kindergarten? _____ Has your child been retained? _____ If so, when _____ How many school has your child attended since entering kindergarten (please list each school by grade) _____
What does your child like about school? _____
What does your child dislike about school? _____
What do you feel are your child's major problems in school? _____
What do you believe are your child's strengths or best qualities? _____

For children from homes where the primary language is Spanish:

Has your child ever attended school where most of his/her instruction was in Spanish? _____ If so, which grades? _____ Was this school in the USA? _____ When did your child first start learning to speak English? _____ At home, which language does the chlid use most of the time? _____

Mother's level of English? (Circle the best answer).	A little	Poor	Good	Excellent
Father's level of English? (Circle the best answer).	A little	Poor	Good	Excellent

Please include any additional information that may be important to this evaluation on a separate sheet of paper. Thank you.

Return this form to: _____ at _____ by _____.