Neuropsychological Consulting Services
834 Kenwood Ave., Suite 3
Slingerlands, NY 12159
Phone: 518-439-1641
Fax: 518-439-1625

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 is the child's and family's racial and/or cultural background?

Are there any cultural factors, issues or concerns you would like me to be aware of?

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?

Please list any developmental or or neurological diagnosis this child currently carries.

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 seen a neurologist? If so, who and when ? ____

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:

What languages are spoken at home?____

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.

Is your child currently receiving counselling or psychotherapy outside of school?

Therapist name and title ______________________________ Reason ________________________________

When? _________________Was the treatment effective? ______________________________________

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? ____

Does this child have an IEP? _____ 504 Plan? _____ Receive AIS or RTI Services __________

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 (**1**st 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 (**2**nd 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: