

## DEVELOPMENTAL HISTORY FORM

Please bring this form to your first meeting, or send via email or mail to the address below. In addition to this completed form, please also provide the following:

1. Copies of **reports** of any previous individual testing (e.g., educational or psychological evaluations, speech/language evaluations, etc.).
2. Copies of school **report cards** and any other relevant records.
3. Copies of **medical reports** where the medical problem is relevant to the present concern(s), such as neurological evaluations or pediatric reports.

Please complete this form with as much detail as you can. If there are some sections you feel uncomfortable completing in writing, I would be pleased to discuss these with you in person. The more information I have, the more completely I can assess and understand your child and the better I can make appropriate recommendations for education support and other treatment. The form is kept in your child's confidential file, subject only to disclosure required by law.

If you are not sure of an answer put in your best guess. Leave the question blank if it is not applicable to your child. Please feel free to add any additional comments as you see fit.

Today's Date: \_\_\_\_\_

Your Child's Full Legal Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Current Age: \_\_\_\_\_

**Name(s) of parent completing this form:** \_\_\_\_\_

Who is your child's legal guardian(s): \_\_\_\_\_

Which parent(s) does your child live with? \_\_\_\_\_

Address and Phone: \_\_\_\_\_

Who else is involved with your child in a *parenting* role? \_\_\_\_\_

Number of other children living *in* the home, with ages and genders: \_\_\_\_\_

\_\_\_\_\_

Number of other children/siblings living *outside* of the home, with ages and genders: \_\_\_\_\_

\_\_\_\_\_



Do you recall using any of the following substances during pregnancy, including the period of pregnancy prior to learning you were pregnant?

Alcoholic beverages

- Never
- Less than 1 drink per week
- 1 - 2 drinks per week
- 3 - 7 drinks per week
- more than 7 drinks per week
- more than 3 drinks on a single occasion

<u>Cigarettes</u>	<u>Mother</u>	<u>Others in the home</u>
Never	<input type="checkbox"/>	<input type="checkbox"/>
Less than 1 per day	<input type="checkbox"/>	<input type="checkbox"/>
1 - 5 per day	<input type="checkbox"/>	<input type="checkbox"/>
6 - 10 per day	<input type="checkbox"/>	<input type="checkbox"/>
11 - 20 per day	<input type="checkbox"/>	<input type="checkbox"/>
More than 20 per day	<input type="checkbox"/>	<input type="checkbox"/>

Did you take any medications during pregnancy? Which and for how long? \_\_\_\_\_

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**Perinatal History**

Did your child's **biological mother** experience any health concerns during pregnancy or delivery, e.g., hypertension or swelling, or blood incompatibility?

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At how many weeks gestation was your child born? (37 to 42 week is considered "term".)

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Were there any complications during labour (e.g., fetal distress, breech birth, emergency caesarian, etc.)?

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What was your child's birth weight? If you can't remember, was it a concern at the time?

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Were there any health complications following birth for mother or baby? Consider breathing and crying, activity level, muscle tone (limp/stiff), colour (normal, blue, or yellow)? If you know the Apgar scores, please note them.

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Did your baby have any interventions at hospital? For example, if your baby was yellow (jaundiced), was phototherapy (lights) used and for how long? Did your baby require oxygen, blood transfusions, intravenous therapy, or did they go to the Neonatal ICU (NICU)?

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Were there any problems with feeding (e.g., latching, sucking, vomiting, or with diarrhea)?

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Any other problems at the time of birth? \_\_\_\_\_

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Total number of days baby was in the hospital after delivery: \_\_\_\_\_

### **Postnatal Period and Infancy**

Did your child experience any health problems during infancy (e.g., feeding problems, colic, sleep difficulties)?

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Was your child an easy baby? Did your child cry a lot, or follow a schedule fairly well?

- Very easy     Easy     Average     Difficult     Very difficult

During Infancy (up to age 2 years) how did your child behave with other people?

- More sociable than average     Average sociability     More unsociable than average

When your child wanted something, how insistent was your child?

- Very insistent     Pretty insistent     Average     Not very insistent     Not at all insistent

How would you rate the activity level of your child as an infant/toddler?

- Very active     Active     Average     Less active     Not active

## Developmental Milestones

To the best of your ability to remember (if you can't remember put 'early', 'average', or 'late'), at what age did your child:

Sit up? \_\_\_\_\_ months      Crawl? \_\_\_\_\_ months      Walk? \_\_\_\_\_ months

Speak single words (other than "mama" or "dada")? \_\_\_\_\_ months

String two or more words together into a phrase? \_\_\_\_\_ months

At what age was your child toilet-trained (Bladder control)? \_\_\_\_\_ years

At what age was your child toilet-trained (Bowel control)? \_\_\_\_\_ years

Rode bicycle (without training wheels) \_\_\_\_\_ years

Dressed self \_\_\_\_\_ years      Tied shoelaces \_\_\_\_\_ years

Named colours \_\_\_\_\_ years

Said alphabet in order \_\_\_\_\_ years      Began to read \_\_\_\_\_ years

## MEDICAL HISTORY

How would you describe your child's current health? Are there any chronic health problems not already discussed above (e.g., asthma, diabetes, heart conditions)? When did these begin?

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When was your child's hearing last tested and were there any problems? \_\_\_\_\_

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When was your child's vision last tested and were there any problems? \_\_\_\_\_

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How is your child's gross motor coordination?       Good       Fair       Poor

How is your child's fine motor coordination?       Good       Fair       Poor

How is your child's speech articulation?       Good       Fair       Poor

Has your child had any *significant* infectious illnesses (e.g., measles, mumps, pneumonia)?

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Has your child ever had a head injury or concussion? If so, at what age(s)?

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How many head injuries or concussions have:

- Included loss of consciousness? \_\_\_\_\_
- Caused memory loss? \_\_\_\_\_
- Caused skull fracture? \_\_\_\_\_
- Caused eye injury? \_\_\_\_\_
- Caused lost teeth? \_\_\_\_\_
- Required sutures/stiches? \_\_\_\_\_
- Required a visit to the Emergency Department? \_\_\_\_\_
- Required CT or MRI Scanning? \_\_\_\_\_

Has your child ever had a seizure (that has not been discussed above)? Was it with fever? How many or how frequently? When did these first occur?

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Has your child had any other severe accidents resulting in serious injury? How many?

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Has your child ever had surgery? If so, please provide type and year of surgery:

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Does your child use alcohol, marijuana, or other drugs? \_\_\_\_\_

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Does your child have any history of physical and/or sexual abuse or neglect? If so, was this investigated by MCFD?

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Does your child have any problems sleeping (e.g., difficulty falling asleep, night-waking, restlessness, or waking up too early, nightmares etc.)?

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Does your child have any current bladder or bowel control problems? \_\_\_\_\_

Does your child have any appetite control problems?  Over-eats  Average  Under-eats

Is your child:  Right-handed  Left-handed  Ambidextrous

At what age did handedness become obvious? \_\_\_\_\_

Do you have a family history of left-handedness? Yes No

Has your child ever changed handedness after handedness was established? Yes No

### HISTORY OF PROFESSIONAL INTERVENTION THERAPY OR TREATMENT

Has your child ever been prescribed medication for anything other than common illnesses of childhood? Specify each drug and for how long:

<u>Medication</u>	<u>How Long?</u>
Current medications:	
_____	_____
_____	_____
_____	_____
_____	_____
Previous medications	
_____	_____
_____	_____
_____	_____

Has your child ever received any psychological or psychiatric treatment? Yes No

If yes, by whom and when? List names of other professionals previously consulted:

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Has your child had a prior psychological assessment? If so, please ensure I have a copy.

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### **SCHOOL HISTORY**

Please list the schools that your child has attended:

Elementary School

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Junior High or Middle School

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High School

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Has your child ever been retained in a grade? Yes No

If yes, which one? \_\_\_\_\_

Please summarize your child's progress (e.g., academic, social, and attendance) within each of these grade levels:

Preschool \_\_\_\_\_

\_\_\_\_\_

Kindergarten \_\_\_\_\_

\_\_\_\_\_

Grades 1 through 5 \_\_\_\_\_

\_\_\_\_\_

Grades 6 through 8 \_\_\_\_\_

\_\_\_\_\_

Grades 9 through 12 \_\_\_\_\_

\_\_\_\_\_

Has your child ever been in any type of special educational program (e.g., Reading Recovery, Learning resource class, behavioural/emotional disorders class) and if so, how long?

\_\_\_\_\_

\_\_\_\_\_

Does your child have a Special Education Designation? If so what is it?

\_\_\_\_\_

Does your child have an Individualized Education Plan? Yes No If so, please provide a copy.

Has your child received extra services at school (e.g., Speech & language therapy, Occupational Therapy, Physiotherapy)?

\_\_\_\_\_

\_\_\_\_\_

Has your child ever been suspended from school: Yes No Expelled from school: Yes No

Has your child had difficulty attending school regularly (or engaging in school activities if home-schooled)?

\_\_\_\_\_

\_\_\_\_\_

Are there any linguistic or cultural issues that have undermined your child's participation in school?

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### 5. SOCIAL HISTORY

How easily does your child make friends?

- Easier than average     Average     Worse than average     Not Sure

On the average, how long does your child keep friendships? \_\_\_\_\_

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What are your child's areas of greatest accomplishment? \_\_\_\_\_

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What does your child enjoy most? \_\_\_\_\_

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What does your child dislike doing most? \_\_\_\_\_

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Does your child participate in sports or athletic activities? If yes, which ones? \_\_\_\_\_

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### CURRENT BEHAVIOURAL CONCERNS

Describe your concerns:

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How have you dealt with these concerns? (Check strategy & which have been successful)

	<u>Caregiver 1</u>	<u>Caregiver 2</u>	<u>Successful?</u>
Verbal reprimands	<input type="checkbox"/>	<input type="checkbox"/>	Y N
Time out (isolation)	<input type="checkbox"/>	<input type="checkbox"/>	Y N
Removal of privileges	<input type="checkbox"/>	<input type="checkbox"/>	Y N
Rewards	<input type="checkbox"/>	<input type="checkbox"/>	Y N
Physical punishment	<input type="checkbox"/>	<input type="checkbox"/>	Y N
Giving in to your child	<input type="checkbox"/>	<input type="checkbox"/>	Y N
Avoidance of your child	<input type="checkbox"/>	<input type="checkbox"/>	Y N

Are there different patterns of behaviour between different environments or caregivers?

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Has your child experienced any significant stress or trauma (e.g., divorce or separation, family accident or illness, death in family, change of schools, family moved, family financial problems?)  
If so, please describe and indicate when?

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### FAMILY HISTORY

Biological Mother: \_\_\_\_\_ Age \_\_\_\_\_

Highest grade completed or degree awarded: \_\_\_\_\_

Current employment/occupation \_\_\_\_\_

Biological Father: \_\_\_\_\_ Age \_\_\_\_\_

Highest grade completed or degree awarded: \_\_\_\_\_

Current employment/occupation \_\_\_\_\_

How long have you and your child's father/mother been married (including common-law relationships)? Please note whether your child was born to a 1<sup>st</sup>, 2<sup>nd</sup>, etc. marriage.

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How stable is your current marriage?       Stable       Unstable

Are there any medical or other conditions that affect children and adolescents in your family, including your extended family of aunts, uncles, and cousins? How many people in the family have any particular condition (that you know of)? What is the degree of relation to your child (i.e., aunt, cousin, sibling)?

	This is in our family	How many people in the family?	What is the relation?
Problems with aggressiveness, defiance, & oppositional behaviour as a child	Y N		
Problems with attention, activity, & impulse control as a child	Y N		
Learning disabilities	Y N		
Did not complete high school	Y N		
Intellectual Disability	Y N		
Autism	Y N		
Psychosis or schizophrenia	Y N		
Depression for greater than 2 weeks	Y N		
Anxiety disorder that impaired adjustment	Y N		
Tics or Tourette's	Y N		
Alcohol abuse	Y N		
Substance abuse	Y N		
Antisocial behaviour (assaults, thefts, etc.)	Y N		
Arrests	Y N		
Physical abuse	Y N		
Sexual abuse	Y N		
Emotional abuse	Y N		

OTHER COMMENTS: