Attachment C

DEVELOPMENTAL HISTORY

I. PERSONAL DATA

A. Child's Name	B. Date of Birth	C. Age	D. Gender
E. Child's Address			
F. Child Lives With			
G. Referred by	H. Informant for this History		

II. HOME AND FAMILY INFORMATION

A. ***Mother*** – 1. Full Name	2. Age
3. Highest Level of Education Completed	4. Occupation
5. Employer	6. Work Phone
B. ***Father*** – 1. Full Name	2. Age
3. Highest Level of Education Completed	4. Occupation
5. Employer	6. Work Phone

C. Marital Status Of Parents	Married	Divorced	Separated	Single

D. Others Living in the Home

Name	*Age*	*Sex*	*Relationship*
1.			
2.			
3.			
4.			
5.			
6.			

E. Native Language Spoken in the Home

F. Describe any changes in the family situation that have affected your child's behavior.

What were the changes in your child's behavior?

III. EDUCATIONAL BACKGROUND

A. 1. Present Preschool or Day Care	2. Phone
3. Address	
4. Teacher	
B. 1. Previous Preschool or Day Care	
2. Address	
C. Did your child have any problems with peers, teacher(s), learning activities? YES NO If so, describe:	
D. If your child did not attend day care or nursery school, who took care of him/her?	
E. Has your child been tested previously? YES NO If so, how can we obtain these results?	

IV. MEDICAL / PHYSICAL INFORMATION

A. Were there any complications during the pregnancy? YES NO Explain:	
B. Any childhood diseases? YES NO List:	
C. Describe any health problems your child has.	
D. Are there any medical reports available? YES NO If so, how may we obtain them?	
E. Have your child ever received services, i.e., speech therapy, PT/OT? YES NO Describe:	
F. Does your child take any medication? YES NO If so, what and for what reason?	
G. Hearing 1. Does your child's hearing seem to be normal? YES NO If abnormal, explain.	
2. Does your child have frequent ear infections? YES NO Does your child have tubes? YES NO	How often? When?
3. Has your child's hearing ever been tested? YES NO When? Does your child wear hearing aids? YES NO	Where? Results? For how long?

H. Vision
1. Does your child's vision seem to be normal? YES NO
If abnormal, explain.

2. Has your child had a visual examination? YES NO Where?	When? Results?

3. Does your child wear glasses? YES NO

I. Motor Skills
1. Does your child exhibit any gross motor problems (i.e., difficulty walking, hopping, jumping, running) as compared to other children his age? YES NO
Describe.

2. Does your child exhibit any fine motor problems (i.e., stacking blocks, buttoning, cutting, zipping) as compared to other children his age? YES NO
Describe.

V. SOCIAL

A. Does your child do what adults tell him to do? YES NO

B. Explain how your child gets along with:
a) siblings:
b) other children:
c) adults:

C. Does your child seem to enjoy:
a) Playing alone? YES NO
b) Playing with other children? YES NO
c) Being with adults? YES NO

D. Does your child make friends easily? YES NO

E. Self-help Tasks (Check only those tasks that the child can perform independently)

___ Dries self with towel	___ Puts on socks	__ Buckles belt
___ Feeds self with fork	___ Puts shoes on correct feet	__ Toilet trained at night
___ Holds cup by handle	___ Dresses self completely except tying	__ Toilet trained during day
___ Brushes teeth	___ Removes coat/shirt with front opening	__ Puts on pulls up pants

VI. LANGUAGE AND SPEECH

A. Does your child seem to understand what is said to him? YES NO

B. Can you understand what your child says? YES NO
If not, why?

C. Can others understand what your child says? YES NO
If not, why?

D. How often does your child use speech?	Frequently?	Occasionally?	Never?

E. Does your child prefer speech or gesture?
SPEECH GESTURE

F. Describe any additional language or speech problems.

VII. COGNITIVE

A. Can your child tell you:

a) his/her name?	YES	NO
b) his/her age?	YES	NO
c) his/her gender?	YES	NO

B. Compared to other children of your child's age, does your child?

___ Look at books independently

___ Enjoy being read to

___ Count three objects

___ Identify differences between tall, short, little, big

___ Count to 3

___ Count to 10

___ Point to colors when named

VIII. ADDITIONAL INFORMATION

A. Please provide any additional information that will help us to understand your child better.

B. What is the best day and time to contact you?

C. What is the best day and time to arrange a meeting with you?

D. INTERVENTIONS (In-School Preschool Ages 3 – 5, not enrolled in Kindergarten)
If interventions were conducted, attach intervention documentation. If a team determined it to be inappropriate to conduct interventions, state reason(s) below.

Form completed by:	Date completed