DEVELOPMENTAL HISTORY

Child's name:____

History obtained by:____

Birthday:________________________ Age:________________________

Telephone:_______________________Date:________________________

Address:____

<u>FAMILY:</u>

Mother's name:________________________ Occupation:________________

Father's name:_________________________ Occupation:________________

Ages of male siblings:____

Ages of female siblings:____

Who resides in the home:____

<u>FAMILY HISTORY:</u>

Are any of your child's siblings in special classes or receiving any type of therapy?

____

Has anyone in your family ever had any speech or learning difficulties?

____

Prenatal care began at__________Month
Mothers RH factor_________________
DID MOTHER HAVE ANY OF THE FOLLOWING DURING PREGNANCY?
*GIVE MONTH

	NO	YES	EXPLAINATION
RUBELLA	_____	_____	_______________________
HIGH FEVERS	_____	_____	_______________________
BLEEDINGHIGH BP	_____	_____	_______________________
EDEMA	_____	_____	_______________________
ACCIDENTS	_____	_____	_______________________
EXCESSIVE	_____	_____	_______________________
VOMITING	_____	_____	_______________________
HOSPITALIZATIONS	_____	_____	_______________________
SURGERY	_____	_____	_______________________
ILLNESS	_____	_____	_______________________
DRUGS	_____	_____	_______________________

DELIVERY:

Birth weight__________________ Full term_______________Premature____________
Duration of Labor_____________ Presentation_________________________________
(Head,breech,caesarean)

Anesthesia was general______________________

Anesthesia was: Local____________Spinal______________None used_____________

Were there any complications? (Infections, hemorrhage, cord around neck etc.)

NO____________YES____________ Explain:

____

____

Did the baby cry immediately? YES_____________ NO________________

Was Oxygen given? YES___________ NO_________________

Were there any obvious birth injuries or abnormalities?

____

Any feeding problems?____

Was the baby nursed or bottle fed?____

Baby healthy and alert (no problems)____

Did the baby go home on the same day as the mother?____________________________

DEVELOPMENTAL HISTORY:
(Give approximate age of occurrence by month or year)

Held head up____________________Feed self with spoon_________________
Sat alone_______________________Bowel training initiated_______________
Crawled________________________Bowel training completed_____________
Walked alone____________________Assist with dressing_________________
Spoke first word__________________Spoke sentences____________________

Energy Level is: High_______ Low________Average___________
Small muscle coordination is : Better than average______ Average_______ Poor_____
Large muscle coordination is : Better than average______ Average________Poor_____
Is there anything unusual about the child's gait?________________________________

SPEECH LANGUAGE AND HEARING DEVELOPMENT:

Language spoken at home:____
Does the child prefer to talk_________gesture________ both talk and gesture_________
Does the child most frequently use sounds_______single words_______2 word sentences
____________3 or more word sentences______________
Did speech learning ever seem to stop for a period of
time?____
Does the child understand what you say to him or her?____________________________
Can he or she follow simple commands?____

CHILD'S MEDICAL HISTORY:

	No	Yes	Age and Details
Allergies	___	___	________________________
Mumps	___	___	________________________
Measles	___	___	________________________
Rubella	___	___	________________________
Meningitis	___	___	________________________
Encephalitis	___	___	________________________
Ear Infections	___	___	________________________
High Fevers	___	___	________________________
Seizures	___	___	________________________

When was the last seizure?____
What kind of seizure was it?____

Does the child have any medical condition such as cerebral palsy, diabetes, asthma etc.? Please list:____
____

	No	Yes	Date
Head injuries	___	___	______
Serious accidents	___	___	______
EEG and /or X-rays	___	___	______
Other illness, surgery etc.	___	___	______

Who are your child's physicians?(Give name, address of physicians and dates last seen)
____
____
____
____

Current medication (include name, amount, times daily___________________________
Has the child ever had their vision or hearing tested? If so what were the results?
____
____

STATEMENT OF THE PROBLEM:

Describe in your own words what problem your child is having with speech, language, hearing, feeding and/or motor skills:
____
____
____
When was the problem first noticed?____
Who noticed the problem?____
What changes if any in your child's development have you noticed since then?
____
Do you have any thoughts on the cause of the problem? If so, please describe:
____
____
Has your child ever received a developmental or speech/language evaluation before? If yes what recommendations were given?
____

Has your child ever or is currently receiving any therapy/services (e.g. speech therapy occupational therapy, physical therapy etc.)?_________________________________

PARENTS DESCRIPTION OF CHILD'S BEHAVIOR (Check off appropriate statements):

____Outgoing	____Impulsive	___ Seeks approval
____Shy	____Cooperative	___Destructive
____Sensitive	____ Happy Child	___Cries often
____Fights often	____Friendly	___Separates easily
____Easily Frustrated	____Fearful	___Needs reminders

____Repeats sounds or words over and over
____Strong reactions to changes in routine or environment
____Displays sense of humor
____Severe temper tantrums and/or frequent minor tantrums
____Gets along well with others

SOCIAL AND EMOTIONAL:

What concerns you most about your child?
____
____

What pleases you most about your child?
____
____

All information is confidential
Thank you for your time