learning ASSESSMENT CENTER

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Child and Adolescent Developmental History

Today's Date: _____
Person Completing this form: _____ Relation to child: _____

A. Client Information

Child's Name: _____ Birthdate:_____ Age:_____

School: _____ Grade: _____
School Contact Person: _____Position: _____Telephone: _____

Describe your current concerns about your child's school performance:
_____
_____
_____
_____

B. Family Information

Parent's Name: _____ Education: _____
Current Occupation: _____ Work Telephone: _____
Email: _____ Okay to leave message? Yes No

Parent's Name: _____ Education: _____
Current Occupation: _____ Work Telephone: _____
Email: _____ Okay to leave message? Yes No

Parents are currently: Married Separated Divorced Never Married
Child's legal custodian/guardian: _____
(Please note: If you are divorced, we require a copy of the custody arrangement for our files.)

Home Address: _____
City: _____ State: _____Zip: _____
Home Telephone: _____ Okay to leave message? Yes No
Cell Telephone: _____Okay to leave message? Yes No

Please list the child's siblings and other members of the household:

Name	Age	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact Person: _____
Relationship to Child: _____ Telephone: _____

Is there a family history of attention disorders (e.g., ADD, ADHD), dyslexia or any other learning disabilities? Yes No
If yes, please explain: _____
_____
_____

C. *Developmental History*

~Prenatal history & Early Development~

Describe any prenatal problems: _____
Indicate if any of the following occurred during pregnancy:

_____ Toxemia
_____ Tobacco Use
_____ Serious Illness/Injury
_____ Prescription Medication Use
_____ Alcohol Use
_____ Frequent Nausea
_____ Illegal drug Use
_____ Serious Illness

Length of pregnancy: _____Weeks
Was the child premature? _____ Weeks
Type of delivery: _____
Were forceps used during delivery?:

Describe any complications during delivery or just after birth: _____
_____
Indicate if the newborn experienced any of the following:

_____ Difficulty breathing _____ Jaundice
_____ Seizures _____ Infection
_____ Heart Problems

Child's birth weight: _____ Condition at birth: _____
Length of hospital stay: Mother? _____ Child? _____

Describe the first few months of life: _____
_____
Indicate if the infant experienced any of the following

_____ sleep difficulties _____ Feeding difficulties _____ Colic

~Developmental Milestones~

When did your child achieve the following developmental milestones:
Sitting without support _____ Crawling _____ Standing alone _____
Walking alone _____ Daytime potty-trained _____ Stayed dry all night _____

Describe the child's speech and language development: _____
When did the child understand words and phrases? _____
When did the child begin using words? _____ Understandable to strangers? _____
When did the child being using sentences? _____ Understandable to strangers? _____
Describe the child's ability to follow directions: _____
Indicate date and results of most recent hearing screening: _____

~Medical History & Current Health Status~

List all major illnesses, hospitalizations, and serious injuries.

Condition	Age	Treatment	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all current health conditions and medications: _____
_____

Name of Medication	Prescribed Dosage	How many times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Pediatrician: _____ Date of last visit: _____

Describe your child's appetite and eating patterns: _____
_____

Describe your child's sleep patterns: _____
_____

Describe your child's motor skills, including handwriting: _____
_____

Describe your child's attention, focus, and level of motor activity: _____
_____

Does your child wear glasses? _____ Have a hearing aid or cochlear Implant?

D. Educational History

Please list all schools your child has attended, beginning with preschool enrollment:

School	Teacher(s)	Age/Grade(s)	Concerns
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your child's current school performance: _____
_____

Describe any concerns related to your child's homework: _____
_____

Describe your child's classroom behavior/interactions: _____
_____

Has your child ever repeated a grade? When? What was the reason?: _____
_____

Describe academic support/specialized services that your child receives at school or outside of school:
_____

List any previous evaluations, including psycho-educational evaluations, speech-language assessment, OT assessment, and educational testing:

Evaluation	Examiner(s)	Date	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Note: Please bring copies of previous evaluations and test scores to the initial testing session.)

List any current or previous therapists (e.g., speech-language, OT, PT, psychologist) that have treated your child:

Type of Therapy	Therapist	Dates	Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

E. *Social Development/Behavior*

Describe your child's temperament and personality: _____
_____

Describe your child's interests, toy preferences, and enjoyable activities:_____
_____

List your child's extra-curricular activities: _____
_____

List activities that your family enjoys doing together: _____
_____

Describe your child's friendships and peer interactions: _____
_____

What discipline methods are most effective with your child: _____

What do you find most difficult about parenting your child: _____
_____

What do you find most enjoyable about parenting your child: _____
_____

Please indicate concerns with any of the following behaviors:

_____ Temper tantrums
_____ Short attention span
_____ Hyperactive
_____ Impulsive/Poor self-control
_____ Low self-esteem
_____ Difficulty getting along with peers
_____ Easily upset/frustrated
_____ Restlessness
_____ Problems following directions
_____ Immature behavior
_____ Withdrawn
_____ Poor social skills
_____ Difficulty getting along with adults
_____ Lacks self-confidence
_____ Unusual behaviors/rituals (Describe: _____)
_____Intense fears (Describe:_____)
_____ Nervous habits (Describe:_____)

F. *Other*

Please feel free to share any additional information that you think would be helpful for this evaluation: _____
_____
_____

Thank you for completing this confidential questionnaire. The information you provided will help to understand all aspects of your child's development so that I provide the most thorough report of your child's learning profile. I look forward to meeting your child and working with your family.

Dr. Leslie Wilson Munson
Licensed Psychologist