Express Yourself
Speech, Language, and Developmental Therapy

DEVELOPMENTAL HISTORY FORM

Instructions to Parents: We appreciate you taking the time to fill it out this detailed history form. This information is very useful in gaining a clear understanding of your child's strengths and weaknesses. Please fill out to the best of your knowledge. If an item is not applicable, simply write N.A. Please feel free to describe or clarify your responses where you think necessary. If needed, attach another page with any additional comments you wish to make.

General Information:
Child's Name:_____

Birth Date:_____

Home Address:_____

Home phone:_____

Cell Phone:_____

Mother's Name:_____ Age:____
Occupation:_____
Mother's occupation before children if different than current:_____

Father's Name:_____ Age:____
Occupation:_____

Mother's Business Phone:_____
Father's Business Phone:_____

Names and ages of brothers and sisters:
_____
_____

Pediatrician:_____
Phone:_____
Address:_____

School currently attending:_____
Grade:_____
Address:_____
Phone:_____
Teacher's Name:_____

Insurance Company:_____
Account number:_____
Phone number:_____

Mother's Health During Pregnancy:
Did the mother:

have any infections/illnesses during pregnancy: Yes_____ No_____
Describe:_____
Have any shocks or unusual stresses during pregnancy (emotional, financial, moves, jobs, losses, etc.)? Yes_____ No_____
Describe:_____
Have depression during or postpartum pregnancy?
Yes_____ No_____
Describe:_____
Receive any medication during pregnancy: Yes_____ No_____
If yes, what kind?
_____
Have complications during labor/delivery? Yes_____ No_____
Describe:_____

Birth History:

Full term _____ Weight at birth:_____

Premature _____ Number of weeks:_____

Post-mature_____ Number of weeks:_____

Labor duration_____

Any anesthesia used?

_____

Was labor induced?

_____

Was this a breech delivery?

_____

Were forceps used?

_____

Was suction used?

_____

Did you have a caesarean?

_____

Complications_____

Was this child one of multiple births (more than one child born as a result of this pregnancy)?

_____

Was the cord around the neck?

_____

Was the baby's color normal?_____ Blue?_____ Yellow?_____

Did the baby cry quickly?

_____

Did the baby have breathing problems?

_____

If known, Apgar score at one minute_____ at five minutes_____

How many days did the mother stay in the hospital?
_____

Did the child go home with mother?
_____

If not, how many days later?_____

Did the baby require intensive care hospitalization
_____

If yes, how long?_____

Did baby receive: Oxygen_____ Length of treatment:_____

Phototherapy_____ Length of treatment:_____

Transfusions_____

Was baby put on a respirator?_____ How long?_____

List any other complications _____

Reaction to delivery and baby by mother and
father._____
_____
_____

Infancy:
Feeding- breast:_____ how long_____
complications_____
bottle:_____ how long_____ complications_____

	YES	NO
Did baby feed well?	_____	_____
Did baby suck well?	_____	_____
Did baby have jaundice?	_____	_____
Did baby have colic?	_____	_____
Was baby difficult to console?	_____	_____
When?_____		
Did the baby fail to grow normally?	_____	_____
Describe._____		
Was the cry weak?	_____	_____
Was the baby normally active?	_____	_____
Describe_____		

Did the baby	YES	NO
seem limp?	_____	_____
seem stiff?	_____	_____
have tremors?	_____	_____
have convulsions?	_____	_____
prefer a certain position?	_____	_____

Describe._____

dislike lying on stomach?	_____	_____
dislike lying on back?	_____	_____
enjoy bouncing?	_____	_____
become calmed by car rides or swings?	_____	_____
become fussy by car rides or swings?	_____	_____

Development:

Sleep:

Does your child:	1st yr.	2-5 yrs.	5-9yrs.	9 on
have regular sleep patterns?	_____	_____	_____	_____
wake frequently in the night?	_____	_____	_____	_____
have difficulty falling asleep?	_____	_____	_____	_____
have sleep problem (i.e. terrors, sleep walking, come to parent's bed)	_____	_____	_____	_____
How long does your child sleep?	_____	_____	_____	_____

Does your child tend to be an early riser, up and on the go? _____

Does your child tend to be slow to arouse in the morning? _____

Feeding:

Problems with:	1st yr.	2-5 yrs.	5-9yrs.	9
Introducing solids	_____	_____	_____	_____
Gagging	_____	_____	_____	_____
Vomiting	_____	_____	_____	_____
Food Allergies	_____	_____	_____	_____
Food habits, fads, rituals	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

Please describe your child's favorite foods:_____

_____

_____

_____

Weaning (describe how accomplished):_____

Pacifier/thumb:_____

Any current eating problems:_____

Use of utensils (spoon, fork, knife; messy, skilled):_____

Open cup:_____

Bowels and Bladder:
Any periods of constipation/diarrhea from infancy to date_____

Toilet Training: describe when started, how handled, who handled. Child's attitude (oppositional, stubborn, frightened, etc.)_____
_____

Problems: (bed wetting, smearing, soiling, etc…)_____
_____

Any regression_____

Developmental Milestones
(Give approximate ages if remembered, or comment on anything unusual)
Raised head_____ cruised furniture_____
Rolled over front to back_____ Walked_____
back to front_____ Chew solid foods_____

Sitting with support_____ Drink from a cup_____

Sitting alone_____

Crawled_____

Was crawling phase brief? Yes_____ No_____
Absent? Yes_____ No_____

Did child come along in development-
quickly_____ normally_____ slowly_____

Did child fall a lot when first walking?
_____

What was his reaction to falling?
_____

Did child experience hesitancy in learning to go down stairs?

_____

Did the child toe walk?

_____

Language:

Spoke first words_____ Good sentence structure_____

2-3 words together_____ Any regression_____

	No	Yes
Drooling past 2 ½ years	_____	_____
Babble as an infant	_____	_____
Speech problems (stuttering, Stammering, "baby talk")	_____	_____

Describe_____

Compared with parental expectations, how does this child's development differ?

_____

_____

_____

Behavior:

Adaptability to new situations and people (infant, toddler, school age, etc….)_____

_____

Response to success_____

Failure_____

Prevalent moods_____

Describe a typical day in your child's life (focus on schedule, activities, and interactions of various family members. Please use the back of this paper if necessary.)_____

_____
_____
_____
_____
_____
_____

Medical History:
Has child received previous evaluation and/or treatment by:
(if yes, when, where and dates of treatment)

Occupational therapy_____
Speech therapy_____
Developmental therapist_____
Floor time practitioner_____
Psychologist_____
Social worker_____

Psychiatrist_____
Other_____

Medical diagnosis (if any):_____

Has child had a vision test?_____ If yes, when?_____

Has child had a hearing test?_____ If yes, when?_____

What were the results of hearing and vision tests?
_____

Has your child had any of the following?
If yes, describe and give approximate dates.
Childhood diseases or major illnesses:_____
Congenital abnormalities:_____
Surgery:_____
Serious injury:_____
Casts or braces:_____
Ear infections:_____
Tubes in ears:_____
Allergies:_____
Asthma:_____

Seizures:_____
Other:_____

Previous medications taken for more than one month
NAME DOSE REASON GIVEN
_____
_____
_____

Present medications
NAME DOSE REASON GIVEN
_____
_____
Have any special tests been done? If yes, describe the tests and results.
_____
_____

School History:
Did the child attend preschool?_____
What age_____Type of classroom_____
Any problems_____

Did the child attend Kindergarten?_____
What age_____
Type of classroom_____ Any problems_____

Grade school- age started_____Any problems?_____

Has your child ever been retained in a grade?_____Which?_____

If child has attended any other schools, list names and years attended.
_____

Has the school reported any difficulties in any of the following (check those that apply.)
Reading_____ Math_____ Spelling_____
Writing_____Following directions_____ Behavior_____
Finishing tasks_____Social Adjustment_____
Attention span_____ Distractibility_____Hyperactivity_____

Organizing work_____ Restlessness_____
Getting along with children_____
Getting along with teachers_____
Describe any problems noted above.

_____
_____
_____
_____
_____

Does your child like school?

_____

Has any psychological testing been done in school?_____

Were you told results?_____

What recommendations were made?_____

Is your child in special education?_____

Type of class_____

At what age was the child placed there_____

Does your child receive any special services in school (resource room, tutoring, remedial reading, speech, etc…).
Type Length

_____

Has child received special help privately _____
Type_____ By whom_____

Family History:
Do you or anyone else in your family have similar difficulties to your child's?_____
If so, please describe:

_____
_____
_____
_____

Social History:
Who lives at home?

_____
_____

Which languages are spoken in your home?

_____

	YES	NO	DURATION
Are there significant marital conflicts in home	____	____	_____
Are there significant conflicts between child and parents?	____	____	_____
Are there significant conflicts between the children?	____	____	_____
Do parents agree how to discipline child?	____	____	

Who disciplines and how (parents, caregiver, extended family)_____
_____
_____

How does child respond to discipline?_____

_____

Does child have difficulty getting along with children his/her own age?_____

_____

Does child have difficulty getting along with adults?_____

Does child have difficulty getting along with brothers and sisters?

_____

_____

Does child have difficulty making/keeping friends?

_____

_____

Reaction to separation from parents

_____

_____

What special interests does your child have?

_____

_____

Play History:

What are your child's favorite play things?

_____

_____

What does he/she do with these toys?

_____

_____

Who does child prefer to play with?

_____

_____

What activities does your child least enjoy?

_____

_____

Are there any things which your child tends to fear or avoid?

Yes____ No_____

If yes, describe:

_____

How long does child play with one toy?
_____

Does child tend to play while in one position more than others?
Yes___ No___
If yes, what position?
_____

Does your child tend to play with things by lining them or piling them (if over two years of age)? Yes___ No___
Describe:_____
_____

What extra-curricular activities are your child involved in (i.e. gymnastics, swimming lessons, Scouts, etc.)
_____