DEVELOPMENTAL HISTORY FORM
2018

Today's Date: _____ / _____ / _____ Person(s) completing this form _____

Child information

Child's Full Name _____

Child's Date of Birth _____ / _____ / _____ Age _____ Grade: _____

Parent information (please CIRCLE best ways to reach parents)

Home phone number (if applicable) : _____

FULL Mailing Address: _____

Parent 1 (P1) name_____ cell number:_____

Email address_____

Highest grade completed: _____ Area of study:_____

Occupation (if home now, indicate that and previous occupation): _____

Parent 2 (P2) name_____ cell number: _____

Email address _____

Highest grade completed: _____ Area of study:_____

Occupation (if home now, indicate that and previous occupation):_____

List Members of household and their ages:

If divorced, please describe custody arrangement:

Referral source and Overall Referral Information

Referral Source (s): _____

Please summarize or list the current reasons that you have decided to secure an assessment at this time

Please describe this child's strengths / areas that come easily to them
(this might include academic, social, personality, athletic, intellectual, or spiritual)

Please describe this child's weaknesses / concerns you have about your child

SCHOOL INFORMATION

Name of current school _____

Full Mailing Address _____

Phone number:_____

Primary Teacher 1 name:_____

T1 email address:_____

If applicable
Teacher 2 name _____

T2 email address:_____

If applicable:
Relevant School Personnel who are involved in supporting your child
(i.e. reading, math, speech or occupational therapist, counselor, 504 coordinator, learning specialist, or administrator involved in supporting learning needs)

Specialist 1 name _____

S1 email address:_____

Specialist 2 name _____

S2 email address:_____

Specialist 3 name _____

S3 email address:_____

Specialist 4 name _____

S4 email address:_____

History of Schools Attended

Grade	Name of School	If other than an expected transition, list reason for change:
Day care		
Preschool		
(Junior K)		
K		
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
College		

Has this child ever repeated a grade? Yes No *(If so which one(s)?* _____*)*

Please describe the main difficulties? Include the grade they were first noticed and how they have shifted over the years. **This can include school and/or parent concerns**

Please circle any of the following that your child has had in the past:

SIT meeting IEP ILP 504 or Accommodation Plan

Please provide copies of any documents that the school has shared with you that contain test scores, the IEP, ILP, 504 or accommodation plan for Dr. O'Hagan to review. If you do not have copies of these forms, please try to get them from your child's school.

Please circle all direct services you child has received at school (outside main classroom instruction)

Reading Math Writing Other Motor Skills Speech Social Skills Groups

Other (please describe)_____

Please circle any of the accommodations that your child has received at school.

Extra time Testing in a separate setting Oral Testing Copies of Notes Spelling

Reduced or shortened assignments Allowed Calculator Allowed multiplication Chart

Foreign Language Waived

Other:

HEALTH HISTORY

Current Health Providers

Pediatrician

Practice name _____

Health Provider who knows your child best: _____

Phone Number:_____

Other CURRENT healthcare providers
(i.e. naturopath, allergist, eye doctor, audiologist, psychiatrist, therapist, speech therapist, occupational therapist, tutor, or any other specialist)

Provider name _____

Area of specialty/reason seen: _____

Phone Number/email:_____

Provider name _____

Area of specialty/reason seen: _____

Phone Number/email:_____

Provider name _____

Area of specialty/reason seen: _____

Phone Number/email:_____

Provider name _____

Area of specialty/reason seen: _____

Phone Number/email:_____

Birth History

Which of the mother's pregnancies was this (1st, 2nd, etc.)?

Age of mother at delivery: _____ Age of father at delivery:_____

What was this child's birth weight? _____ pounds, ____ ounces

Was this child full term? Yes No

Please describe any problems that occurred during pregnancy or delivery with either mother or child:

Does this child have a **history of ear infections**? Yes (describe below) No

Any specific cause / type	Age(s)	Duration	Treatment

Does this child have **a history of seizures or convulsions**? Yes (describe below) No

Cause (if known)	Age(s)	Duration	Treatment

Does this child have **allergies or asthma**? Yes (describe below) No

If yes – please list allergens, any medications / treatment, how well managed they are, whether injections have/are received and whether this interferes with any activities, including sleeping

Does this child have frequent **headaches, stomach-aches and/or vomiting**? Yes (describe below) No

If yes – please describe any known causes or patterns to these occurring (summer vs. school year, time of day, day of the week) and how treated

Please list any other diagnosed **physical or mental health problems or genetic conditions**.

Type of Illness/Condition	Age	Description/ Treatment

Please list any other **serious illnesses** this child has experienced, age and describe as appropriate.

Type of Illness	Age	Description/ Treatment

Please list any **serious accidents** this child has had.

Type of accident/injuries incurred	Age	Description/Treatment

Please list **any additional hospitalizations** this child has had (not listed above).

Reason for hospitalization	Age	Description

CURRENT medications (prescription and over-the-counter): Please list

Name of medication	Dosage	Reason for medication

CURRENT supplements or vitamins: Please list

Name of supplement	Dosage	Reason for supplement

PAST medications or supplements (Please list)

Name of medication	Dosage	Reason for medication

Any hearing issues?

Date of **most recent hearing check** (month/year):

Completed by / at:

Outcome/recommendations:

Any vision issues?

Has vision therapy ever been recommended or received? Yes (please describe) No

Does this child wear contacts or glasses? Yes No
(If yes – please make sure these are brought to the assessment)

Date of **most recent vision check** (month/year):

Completed by / at:

Outcome/recommendations:

Has this child had **a speech evaluation or received speech therapy?** Yes (please describe) No

Name (s) of therapist (s) / Agency	Dates/Age/Grade seen	Focus of treatment (articulation, broader language)

Has this child ever had an **OT evaluation or been seen by an OT** ? Yes (please describe) No

Name (s) of therapist(s) ? Agency	Dates / Age / Grade seen	Focus of treatment (gross, fine, sensory)

Has this child ever had a **private educational, or psychologist evaluation**? Yes (please describe) No

Name of examiner / Agency	Date / Age / Grade	Focus / reason for evaluation / Any diagnoses made

Has this child ever been followed by a **psychiatrist**? Yes (please describe) No

Name of psychiatrist	Date / Age / Grade	Focus / reason for consultation / Any diagnoses made / any treatment prescribed

Has this child ever received **tutoring**? Yes (please describe) No

Name(s) of tutor(s)	Dates / age / grade	focus of tutoring

Has this child ever received **counseling** (individual, group or family)? Yes (please describe) No

Name(s) of therapist(s)	Dates / age / grade	Focus of therapy

Compared to other children, **please mark any of the following areas that were problematic or delayed** (or for which they have been treated) If it is an area of concern, please describe, noting whether treatment was received and whether it is currently an issue.

Skill / interest area	X if a concern	Description of difficulty this child had	**Currently** an issue?
understanding speech (receptive skills)			
learning to talk (e.g. first talking and quality of articulation; expressive skills)			
gross motor skills (e.g. walking, hopping, running, riding a bike, etc.)			
fine motor skills (e.g. buttons, zippers, tying shoelaces, pencil grip)			
Building with blocks, doing puzzles			
Drawing			
Writing (i.e. quality of handwriting)			
Being able to sit still			
Playing with same-aged peers			
Separating from parents			
Toilet training			
Sleeping on own			
Eating			
Other:			

Compared to other children, **please mark any of the following areas that were slow to develop, challenging to this child or which they do less quickly or automatically than you would expect.** If it is an area of concern, please describe, noting whether it continues to present difficulties currently.

Skill Area	**X** if a concern	Description of difficulty this child had	**Currently** an issue?
Naming colors or shapes			
Names of letters			
Sounds of letters (making the sound-letter connection)			
Reading Comprehension			
Writing letters accurately			
Writing numbers accurately			
Names of numbers			
Counting			
Math concepts			
Early math facts (adding/subtracting)			
Timed math (i.e. mad minute)			
Multiplication facts			
Sequential information (days / week, months/year)			
Relational terms (today / yesterday/tomorrow; above/below; after/before)			
Rote memorization (birth date, phone number, address)			
Differentiating Left from Right			
Rhyming ability			
Identifying coins / understanding coin value			
Telling time			
Other:			

Please list your child's involvement in any extra-curricular activities (include sports, dance, clubs, structured activities). Please include the time commitment for each (i.e. weekly, 5 days/week, only in spring, etc)

If relevant, please describe any family circumstances or life events that you feel may be relevant to understanding this child. This could include changes in residence or jobs, family conflict, job loss, deaths or illness of family or friends, etc.

List anyone in immediate or extended family who has had difficulties in school (trouble learning to read, etc), dropped out, or 'underachieved' OR has been formally diagnosed with a learning disability, ADD or AD/HD

Person (relation to child) (Parents, grandparents, siblings, cousins)	**Learning Difficulty** (reading, writing, math, foreign languages, etc.)

List anyone in the immediate or extended family who has had behavioral, emotional, or substance use issues

Person (relation to child)	**Behavioral or emotional difficulty** (overactive, anxious, depressed, legal problems, substance use)

Please list any health problems experienced by immediate or extended family (neurological, immunological, genetic, diabetes, pulmonary, respiratory, or any other health problems):

Person (relation to child)	**Health Difficulty**

Finally, please **gather the following documents** and either (1) email them, (2) mail them back with the history form, (3) drop them off at my office, or (4) bring to the intake session. If it is easiest to give us the originals (especially in relation to longer documents like IEPs) that is fine.

If you drop them off and the suite door is open, please leave them on the counter to your right by the sink; if the door is locked, please put them in the mail slot in the door. Please email or text me when you drop them off so I know they are there. If you share originals, we will be sure to give them back to you after the assessment is completed.

Please include any of the following documents if they apply:

1. Copies of previous assessments completed (**any** assessments: educational, psychological, speech, OT, vision, hearing, etc.)

2. Previous standardized test scores received going back as far as you can (ITBS, Terra Nova, ERB, Plan, Explore, PSAT, ACT. SAT, etc.)

3. Any school-based benchmark testing that has been shared with you (usually in reading or math), again going back as far as you can (i.e. preschool/kindergarten screenings, DIBELS, STAR testing, MAPS testing, etc.)

4. Report cards

5. Official school documents (previous and current accommodation plan, 504, IEP, etc.)

6. Anything else you think is helpful for understanding your child.

7. If you have a younger child and I will be completing a school observation, please also include a picture of them to facilitate my ability to quickly identify them in the classroom.