LANDSTROM CENTER
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Developmental History

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Form completed by: _____ Relationship to child: _____

Date form completed: _____

General Information -

Child's Name: _____ Gender: ☐ Male ☐ Female
First Middle Last

Date of Birth: _____ Age: _____

Child's Address: _____
Number and Street City State Zip

Home phone: _____ Ethnic/Cultural Background (optional) _____

Primary language spoken in the home: _____ Other language spoken in the home: _____

Current Concerns

What is the main reason for your child's referral today? _____

_____

How long has your child had these problems? _____

_____

What are you hoping to achieve at the completion of this evaluation?_____

_____

Services/Interventions Sought Previously

☐ Medical Evaluation	☐ Neuropsychological Assessment	☐ Educational Testing	☐ Psychiatric Exam
☐ Medication	☐ Neurological Exam	☐ Speech/Language Therapy	☐ Special Education
☐ School Modifications	☐ Psychological Counseling or Therapy	☐ Occupational/Physical Therapy	☐ Tutoring

Has your child had any of the following forms of psychological treatment? If so, how long did it last?

Individual psychotherapy	☐ Yes	☐ No	Duration of therapy? _____
Group psychotherapy	☐ Yes	☐ No	Duration of therapy? _____
Parenting classes	☐ Yes	☐ No	Duration of classes? _____
Residential treatment	☐ Yes	☐ No	Duration of placement? _____

Is your child currently receiving psychological treatment? If so, with whom and how often? _____

_____

What else have you tried to do to help your child with these problems, and how effective were these interventions?

_____

_____

Family History

(Please circle: Birth, Adoptive, or Foster)
Birth / Adoptive / Foster Mother's Name: _____ Age _____ Education (Yrs) _____
Address (if different from child's) _____
_____
Occupation: _____ Employer _____
Work Phone: _____ Home Phone: _____

Birth / Adoptive / Foster Father's Name: _____ Age _____ Education (Yrs) _____
Address (if different from child's) _____
_____
Occupation: _____ Employer _____
Work Phone: _____ Home Phone: _____

Stepmother's Name: _____Age _____ Education (Yrs) _____
Address (if different from child's) _____
_____
Occupation: _____ Employer _____
Work Phone: _____ Home Phone: _____

Stepfather's Name: _____ Age _____ Education (Yrs) _____
Address (if different from child's) _____

_____

Occupation: _____ Employer _____
Work Phone: _____ Home Phone: _____

Other Guardian's Name: _____ Age _____ Education (Yrs) _____
Address (if different from child's) _____

_____

Occupation: _____ Employer _____
Work Phone: _____ Home Phone: _____
Relationship to child: _____

Foster/Adoptive Information:

(Please complete this information only if the child has ever been adopted or placed in foster care)

What age was the child first placed in foster care? _____

Why was the child placed in foster care? _____

_____

Who has legal custody of the child? _____

Name of child's social worker: _____ Phone number _____

Social worker address: _____

Has the social worker provided consent for this evaluation? ☐ Yes ☐ No

(If YES, please attach authorization; If NO, please request authorization from county social services)

Is the child adopted? ☐ Yes ☐ No If yes, specify country of origin if international _____

Age when child was first in home: _____ Date of legal adoption: _____
If the child was adopted, do they know they were adopted? ☐ Yes ☐ No

How many different foster care / adoptive placements has the child experienced? _____

What type of placements has the child experienced (e.g., orphanage, foster home, group home, shelter care, kinship home, hospitalization, etc.): _____

_____

Does the child have any contact with biological parents? ☐ Yes ☐ No

If yes, with whom, how often, are the visits supervised, how does the child respond after the visits?

_____

_____

If the child is not yet adopted, is there a plan for this to happen? ☐ Yes ☐ No

If yes, what is the time frame? _____

How has the child adjusted to foster care / adoption? _____

_____

List all people with whom the child currently resides:

Names of Household Members	**Age**	**Gender M / F**	**Relationship to Child**	**Highest Grade Completed**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If any brothers or sisters are living outside the home, list their names, ages, where they are living, and why they are no longer in your home: _____

_____

Are parents separated or divorced: □ No □ Yes (describe below)
When did you separate/divorce? _____
Who has physical custody of child? _____
Who has legal custody of the child? _____
How often does the other parent see this child? _____

Have there been any major changes within the family life or the child's living situation that have affected your child's development (e.g., deaths, moves, divorces, loss of job, etc)? □ No □ Yes (describe below)

Event	Date	Child's Age
_____		
_____		
_____		
_____		

Pre-Natal Period

Did mother receive prenatal care during the pregnancy? ☐ Yes ☐ No Starting in which month? _____

Number of the following the mother of the child has had (including the child being evaluated):
Pregnancies _____ Miscarriages _____ Premature births _____

Did mother have any of the following during or immediately before/after the pregnancy (check all that apply)

☐ Emotional stress	☐ Infections (cold, flu)	☐ Preterm labor/bedrest
☐ Toxemia	☐ Anemia	☐ Abnormal weight gain
☐ Excessive swelling (edema)	☐ Measles/German measles	☐ Excessive vomiting
☐ Flu	☐ High blood pressure	☐ Kidney disease
☐ Vaginal bleeding (when? _____)	☐ Strep throat	☐ Threatened miscarriage
☐ Epilepsy/seizure	☐ X-ray studies	☐ Fever
☐ Other (Rh incompatibility, etc.)	☐ Diabetes	☐ Other virus

☐ Maternal injury. Describe: _____
☐ Operation/hospitalization during pregnancy. Reason: _____

Were any of the following used during pregnancy? (check all that apply)

☐ Prescribed medications. (Please specify): _____ For: _____

☐ Tobacco	☐ Marijuana	☐ Methamphetamines
☐ Amphetamines	☐ Heroin	☐ Methadone
☐ Cocaine	☐ Alcohol	☐ Other (specify) _____

Birth History

Age of mother at birth? _____ Age of father at birth? _____

Was infant born full term? ☐ Yes ☐ No Number weeks gestation _____

Birth weight: _____ lbs. _____ oz. Apgars (if remembered) _____ at 1 min _____ at 5 min.

Type of Labor Onset: ☐ Induced ☐ Spontaneous

Type of Birth: ☐ Vaginal ☐ C/Section (Planned? ☐ Yes ☐ No - Emergency? ☐ Yes ☐ No)
☐ Vaginal Birth after C/Section (VBAC) ☐ With instruments (forceps)

Type of Anesthesia: ☐ Gas ☐ Spinal ☐ Local ☐ None

Baby's Presentation: ☐ Breech ☐ Head ☐ Transverse (sideways)

Please check the following problems that may have occurred during labor:

Yes	No		Yes	No	
☐	☐	Toxemia/eclampsia	☐	☐	Fetal distress
☐	☐	Maternal fever	☐	☐	Medications used (please specify): _____

Length of active labor: _____ hours. Describe any complications during delivery:_____
_____

Post-Delivery Period

Check which of the following problems may have occurred after the child's birth and explain the amount and treatment in the space below:

Yes	No		Yes	No	
☐	☐	Trouble breathing	☐	☐	Jaundice
☐	☐	Cord around the neck (# of times ____)	☐	☐	Poor feeding
☐	☐	Knot in cord	☐	☐	Required a blood transfusion
☐	☐	Seizures	☐	☐	Vomiting / reflux
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Floppy muscle tone
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Incubator care
☐	☐	Cyanosis (turned blue)	☐	☐	Infection
☐	☐	Need for ventilation	☐	☐	Fever

Please explain all "Yes" answers:

_____

_____

Did infant require X-ray/ CT scan? ☐ No ☐ Yes
Was infant placed in the NICU? ☐ No ☐ Yes If yes, how long: _____

Length of stay in hospital: Mother: _____ days. Infant: _____ days.

Developmental History

Was any of the following present in your baby during the first few years of life? If so, please describe:

Yes	No		Yes	No	
☐	☐	Did not enjoy cuddling	☐	☐	Was not calmed by being held or stroked
☐	☐	Difficult to comfort	☐	☐	Excessive restlessness
☐	☐	Excessive irritability	☐	☐	Frequent head banging
☐	☐	Difficult feeding	☐	☐	Sleeping difficulties
☐	☐	Extremely passive	☐	☐	Early learning problems
☐	☐	Temper tantrums	☐	☐	Withdrawn behavior
☐	☐	Convulsions	☐	☐	Poor eye contact
☐	☐	Colic	☐	☐	Unable to separate from parent
☐	☐	Destructive behavior	☐	☐	Failure to thrive/poor weight gain
☐	☐	Breathing problems			

Was your child adaptable, easy to please and easy to discipline as an infant and toddler? ☐ Yes ☐ No
If no, please describe: _____

_____

As an infant and toddler, was your child interested in social contact (eye contact, social smile, showing things, sharing experiences)? ☐ Yes ☐ No If no, please describe: _____

_____

As an infant and toddler, describe your child regarding his/her ease of self-regulation (e.g., ability to settle down at night, calm self when upset, etc.)? _____

_____

Please list the approximate age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A. If unsure, please write DK.

Age:		Age:	
_____	Smile in response (social smile)	_____	Know primary colors
_____	Sit independently	_____	Say the letters of the alphabet
_____	Crawl independently	_____	Print first and last name
_____	Walk independently	_____	Tie shoes
_____	Say "mama" or "dada" specifically	_____	Snap, zip, button clothing
_____	Say 1st word other than "mama" or "dada"	_____	Began to read
_____	Put two words together	_____	Toilet trained (urine)
_____	Put 4-5 sent. together to relate an experience	_____	Toilet trained (bowel)
_____	You understood 100% of what child said		

Has your child ever lost skills that at one time he/she was able to perform? ☐ Yes ☐ No
If yes, please explain: _____

Are there any concerns related to toilet training? ☐ Yes ☐ No
If yes, please describe: _____

Medical/Health History

What was the date your child's last physical exam? _____

Child's physician_____ Phone number _____

Vision problem? ☐ Yes ☐ No Date of last vision exam: _____

Hearing problem? ☐ Yes ☐ No Date of last hearing exam: _____

Appetite concerns? ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight loss/ gain

Oral-motor concerns? ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Where does your child sleep? ☐ Own bedroom ☐ Bedroom parent(s) sleep in ☐ Shared bedroom with _____

Does your child have problems falling asleep? ☐ Yes ☐ No
If a yes, how long does it take for him/her to fall asleep? _____ hours

Does your child wake up in the middle of the night? ☐ Yes ☐ No

If Yes, how many times per night typically? _____
How long does it take for him/her to go back to sleep? _____
How many hours does your child currently sleep at night? _____

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

Has your child been given a specific diagnosis?

- ☐ Learning disability
- ☐ Language disorder
- ☐ Attention Deficit Disorder (ADHD)
- ☐ Oppositional Defiant Disorder (ODD)
- ☐ Autism/ Asperger's/ PDD
- ☐ Other _____
- ☐ Mental Retardation
- ☐ Developmental Delay
- ☐ Epilepsy
- ☐ Tourette's Disorder
- ☐ Fragile X
- ☐ Genetic Disorder _____
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia

Surgeries: Age: _____ Reason: _____ Where: _____
Other details _____

Hospitalizations: Age: _____ Reason: _____ Where: _____
Other details _____

Major accidents or injuries: Age: _____ Type (head, abdomen, fracture, etc.) _____
Other details _____

Has your child ever been unconscious? ☐ Yes ☐ No If yes, please explain: _____
_____

Does your child have current problems with:

	Yes	No	?		Yes	No	?
Ears (specify) _____				**Appetite, digestion, stomach problems**			
Poor Hearing				Frequent stomach aches			
Chronic earaches/ infections				Poor eating habits			
Draining ears				Frequent vomiting			
				Soiling or daytime accidents			
Eyes (specify) _____				Constipation			
Poor vision				Problems with weight			
Crossed eyes							
Wears glasses							

	Yes	No	?		Yes	No	?
Endocrine/ Gland				**Blood Disorder**			
Thyroid problems				Anemia			
Diabetes				Excessive bleeding or bruising			
Hypo/Hyperpituitarism				Leukemia			
Growth problems				Sickle cell disease			
Other: _____				Other_____			
Nervous system				**Urine or bladder** problems			
Frequent and/ or severe headaches				Bedwetting			
Seizures or convulsions				Daytime wetting or accidents			
Tremors or twitches				Urine infections			
Paper and pencil coordination problems				Other _____			
Balance or coordination problems							
Other _____				**Chest or Breathing**			
				Wheezing/ asthma			
				Other: _____			

Has your child had any of the following?

Ear Tubes	☐ Yes	☐ No	If yes, number of tube placements _____
Encephalitis	☐ Yes	☐ No	
Meningitis	☐ Yes	☐ No	
Poisoning or drug intoxication	☐ Yes	☐ No	
Coma	☐ Yes	☐ No	
Staring spells	☐ Yes	☐ No	
Immune system disorders	☐ Yes	☐ No	
Other significant illness	☐ Yes	☐ No	

If yes to any of the above, please describe: _____

_____

Has your child had any of the following tests or evaluations?

	Yes	Date (month/ year)	Where	Results
Neurologic Evaluation				☐ Normal ☐ Abnormal ☐ Don't Know
CT scan of head				☐ Normal ☐ Abnormal ☐ Don't Know
MRI scan of head				☐ Normal ☐ Abnormal ☐ Don't Know
EEG				☐ Normal ☐ Abnormal ☐ Don't Know
Audiology or hearing evaluation				☐ Normal ☐ Abnormal ☐ Don't Know
Vision evaluation				☐ Normal ☐ Abnormal ☐ Don't Know
Genetic Testing				☐ Normal ☐ Abnormal ☐ Don't Know
Other laboratory tests				☐ Normal ☐ Abnormal ☐ Don't Know

Family Medical History

Mother: Health, learning, mental health problems? (please specify) _____

_____

Father: Health, learning, mental health problems? (please specify) _____

_____

Child's siblings: Health, learning, mental health problems? (please specify)_____

_____

Have any of the child's family members had the following problems/disorders? Please specify the family member's relationship to the child and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

	Family Member(s) Relation to Child		Family Member(s) Relation to Child
☐ Birth defect	_____	☐ Reading problem	_____
☐ Genetic disorder	_____	☐ Other learning disability	_____
☐ Cerebral palsy	_____	☐ Speech/ language delay	_____
☐ Severe head injury	_____	☐ Did not graduate from high school	_____
☐ Migraine headaches	_____	☐ Mental retardation	_____
☐ Multiple sclerosis	_____	☐ Autism/ Aspergers/ PDD	_____
☐ Physical handicap	_____	☐ ADHD	_____
☐ Tuberous sclerosis	_____	☐ Oppositional/ defiant behaviors	_____
☐ Huntington's chorea	_____	☐ Antisocial behavior	_____
☐ Muscular dystrophy	_____	☐ Aggression	_____
☐ Sickle-cell anemia	_____	☐ Tics/ Tourette's Disorder	_____
☐ Seizures or epilepsy	_____	☐ Nervousness/ anxiety	_____
☐ Cancer	_____	☐ Obsessive-Compulsive Disorder	_____
☐ Diabetes	_____	☐ Depression	_____
☐ Heart Disease	_____	Bipolar/ manic depressive disorder	_____
☐ Alcohol/ Drug abuse	_____	☐ Schizophrenia	_____
☐ Physical/ sexual abuse	_____	☐ Other (specify)	_____

Have any maternal family members ever received extra help in school, early intervention, or special education services?

☐ Yes ☐ No

If yes, specify who and the reason _____

_____

Personal/Social Information

What are your child's main hobbies and interests?

_____

What about your child makes you most proud?

_____

What does your child dislike doing most?

_____

How many close friends does your child have? _____

Does your child have a best friend? ☐ Yes ☐ No If yes, how old is he or she? _____

How long have they been friends? _____ years _____ months

How easily does your child make friends? ☐ Worse than average ☐ Average ☐ Better than average

Does your child have problems keeping friends? ☐ Yes ☐ No

How well does your child get along with friends? ☐ Worse than average ☐ Average ☐ Better than average

If Below Average, please explain: _____

Does your child get along best with: ☐ Older children ☐ Children of the same age ☐ Younger children

Educational History

Has your child received Early Childhood Intervention services? ☐ Yes (Dates: _____) ☐ No

Did your child attend preschool? ☐ Yes ☐ No If yes, at what age? _____

Name of preschool: _____

Were there any adjustment problems in preschool? ☐ Yes ☐ No

Were you concerned about your child's ability to succeed in preschool? ☐ Yes ☐ No

Name of child's current school: _____

School district: _____

Address of school: _____

Telephone: _____ Grade: _____ Teacher: _____

Has your child ever been retained? ☐ Yes ☐ No What grade? _____ Why? _____

Is your child absent from school: ☐ Often ☐ Seldom ☐ Never

Usual reason for absence _____

If your child is in school please, comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with teachers					
Relationship with peers					
Participation in organized activities (e.g., teams)					

Has testing been completed by school or outside clinic? ☐ Yes ☐ No Date: _____
(Please attach a copy of the school evaluation)

Present class placement: ☐ Regular class ☐ Special class (if so, specify) _____
☐ Bilingual/ESL ☐ Gifted & Talented

Does your child have an IEP (Individualized Education Plan)? ☐ Yes ☐ No
Does your child have a 504 Plan? ☐ Yes ☐ No

If yes, for what reason? _____
(*Please attach a copy of the IEP/504 Plan)*

Special Education Categories: Please check all that apply (specify since what grade child has been in this placement):

☐ Autism Spectrum Disorder (ASD) Grade: _____
☐ Communication Disorder Grade: _____
☐ Deaf-blind Grade: _____
☐ Developmental Delay Grade: _____
☐ Emotional Disability (ED) Grade: _____
☐ Hearing Impairment Grade: _____
☐ Learning Disability (LD) Grade: _____
☐ Mental Disability Grade: _____
☐ Multiple Disabilities Grade: _____
☐ Orthopedic Impairment Grade: _____
☐ Other Health Impairment (OHI) Grade: _____
☐ Traumatic Brain Injury Grade: _____
☐ Visual Impairment Grade: _____

Have any of the following instructional modifications been attempted?

- ☐ Oral tests
- ☐ Additional instructions
- ☐ Manipulatives in math
- ☐ Preferential seating
- ☐ Extended time to complete assignments
- ☐ Shortened or modified assignments
- ☐ Study Sheets
- ☐ Control of distractions
- ☐ Behavior modification program
- ☐ Peer teaching
- ☐ Reduced paper and pencil work
- ☐ Repeated review
- ☐ Study carrel
- ☐ Outlines
- ☐ Positive reinforcers
- ☐ Behavior check cards / charts
- ☐ Predictable routines and classroom rules
- ☐ Increased positive feedback
- ☐ Technologic assistance (word processor, calculator, augmentative communication device, etc.)
- ☐ Other _____

How successful have the above interventions been?_____

Behavior and Discipline

Please describe briefly any behavioral problems at school: _____

_____

Please describe briefly any behavioral problems at home:

_____

_____

Does your child currently (within the past 6 months) display any of the following behaviors frequently?

☐ Fainting, falling	☐ Anxiety	☐ Low frustration tolerance	☐ Physical aggression
☐ Clumsiness	☐ Unusual fears	☐ Impulsivity	☐ Stealing
☐ Shy, timid	☐ Avoidance	☐ Hyperactivity	☐ Use of profanity
☐ Social Isolation	☐ Laziness	☐ Attention seeking	☐ Skipping school
☐ Lack of confidence	☐ Obsessive-compulsive behaviors	☐ Irritability	☐ Fire setting
☐ Low self-esteem	☐ Stereotyped/repetitive behaviors	☐ Temper tantrums	☐ Destructiveness
☐ Crying episodes	☐ Memory loss	☐ Oppositional behavior	☐ Cruelty to animals
☐ Unhappiness	☐ Poor concentration	☐ Noncompliance	☐ Gang Involvement
☐ Concern with weight	☐ Short attention span	☐ Defiance	☐ Cigarette use
☐ Sleep problem	☐ Distractibility	☐ Lying	☐ Alcohol / Substance use
☐ Other:			