



Developmental History

Was the birth at full term? Yes No
If no, how many weeks of gestation? _____ weeks
Birth weight: _____ pounds _____ ounces
Was there a C-section? Yes No If yes, was it planned? Yes No
Did your child spend time in the NICU? Yes No If yes, how long? _____
Complications: _____
Was there smoking/alcohol/substance use during pregnancy? Yes No
If yes, list _____
Did your child demonstrate excessive crying or colic? Yes No
Were there feeding or eating difficulties? Yes No Are they current? Yes No
Were there sleeping difficulties? Yes No Are they current? Yes No
What time does child currently fall asleep: _____ Wake up time: _____
Is the bedtime routine a struggle? Yes No
Does your child wake up frequently during the night? Yes No
Does your child wet the bed more than once per week? Yes No

Developmental Milestones

Speech: On time Delayed By how long? _____
Walking: On time Delayed By how long? _____
Toilet training: On time Delayed When was it achieved? _____
Has your child attended Speech therapy? Yes No When _____
Has your child attended Occupational therapy? Yes No When _____

Behavior

What percent of the time does your child follow directions the first time they are given?
At home: _____ % At school: _____ %
Comments: _____
How is misbehavior managed? _____
Is it effective? Yes No

Friendships

Describe your child's relationships with peers/friends: _____

School

Typical grades for your child _____
Favorite subject _____ Least favorite subject _____
Has your child repeated a grade? Yes No If yes, what grade? _____
Has your child been suspended? Yes No If yes, how many times? _____
Has your child been expelled? Yes No If yes, what grade(s)? _____