Developmental Diagnostics, LLC
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CLIENT INFORMATION

Parent/Guardian(s) Name: ______________________________

Child's Legal Name: ______________________________

Child's Address: ______________________________

City: ____________________ State: __________ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________

Birth Date: ____________ Age: ______ Sex: _____ Soc. Sec. # ______________

Referred By: ______________________________

What are the problems that caused you to seek help for this child? ______________________________

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Name of adults living in your home	Relationship	Age	Occupation

Name of children living in your home	Relationship	Sex	Age	School/Behavioral/Health Problems

Family History:

Is the child adopted?

☐ Yes ☐ No If yes, with which parent(s) (if any) does the child live?

☐ Natural ☐ Adoptive Child's age at adoption ______________________

Status of parents' marriage:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

How long married? __________ How long divorced? ______ Child's age at divorce ______________

	Birth Mother	Birth Father
Age:	______________________	______________________
Highest graded completed:	______________________	______________________
Diploma/Degree:	______________________	______________________
Occupation:	______________________	______________________

Please describe any special education or tutoring:

______________________ ______________________

Please describe any grades repeated or subjects failed:

______________________ ______________________

Please describe any learning difficulty, and subject and grade level at which it occurred:

______________________ ______________________

Please describe any psychological or psychiatric problems for which treatment was received: (i.e., depression, anxiety)

______________________ ______________________

Any Attention-Deficit Disorder or hyperactivity? Please describe treatment:

______________________ ______________________

Adoptive Mother or Stepmother or Other___________ (Circle One)

Age: ______________________________

Highest grade completed: ______________

Occupation: __________________________

Adoptive Father or Stepfather or Other____________ (Circle One)

Age: ______________________________

Highest grade completed: ______________

Occupation: __________________________

Biological Extended Family

Do any immediate or extended family members (parents, maternal/paternal grandparents, uncles, aunts, cousins) suffer from a problem with inattention or hyperactivity; epilepsy; seizures; migraines; alcoholism or substance abuse; psychological, emotional, or personality difficulty; learning problems or developmental disabilities; and/or "nervous" or neurological disorder; etc.? ☐ Yes ☐ No

If yes, please list relationship to child/adolescent, disorder, and any treatment received.

Maternal (mother's side)	Paternal (Father's side)
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Birth and Developmental History

PREGNANCY

Length in months______________

Any illnesses or complications while pregnant? ☐ Yes ☐ No

If yes, please explain ____

Medications taken by the mother **during** pregnancy? _____________________________________

Substances used **during** pregnancy:

- ☐ Cigarettes — How many?_______ Per (☐ Day ☐ Week)
- ☐ Alcohol — How many drinks?_____ Per (☐ Day ☐ Week ☐ Month)
- ☐ Drugs — Please describe type(s) of drug, frequency of use, and at what month of pregnancy use was stopped (if applicable).

  ____

Was the father taking any medications or drugs at time of conception? If so, what?

____

How many pregnancies and/or miscarriages has the mother had?____________________________

____

LABOR AND DELIVERY

Was the birth of the child "normal"? ☐ Yes ☐ No If no, please explain.

____

____

Do you think the child's problems might be related to pregnancy, labor, or delivery?

☐ Yes ☐ No If yes, please explain.

____

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PERINATAL HISTORY

Birth weight________________Length______________APGAR scores______________________

Did mother or baby stay in Special or Intensive Care? ☐ Yes ☐ No

Please describe any problems. ____

____

____

Please list any abnormalities discovered at birth.

____

____

____

INFANCY AND EARLY CHILDHOOD

Please rate the child on the following behaviors: Circle 1 if the behavior on the left was present the majority of the time. Circle 5 if the behavior on the right was present the majority of the time. Stages in between are represented by 2, 3, and 4. If there are two behaviors listed (e.g., tantrums and head banging), please check the one that was present.

Quiet and Content	1	2	3	4	5	Colicky and irritable
Very easy to feed	1	2	3	4	5	Daily feeding problems
Slept well	1	2	3	4	5	Frequent sleeping problems
Usually relaxed	1	2	3	4	5	Often restless
Underactive	1	2	3	4	5	Overactive
Cuddly, easy to hold	1	2	3	4	5	Did not enjoy cuddling
Easily calmed down	1	2	3	4	5	☐ Tantrums ☐ Head banging
Cautious and careful	1	2	3	4	5	☐ Accident prone ☐ Daredevil
Coordinated	1	2	3	4	5	Uncoordinated
Enjoyed eye contact	1	2	3	4	5	Avoided eye contact
Liked people	1	2	3	4	5	Disliked contact with people

Other problems or comments regarding infancy or early childhood development:

___

___

___

___

Did any event, health condition, separation, etc., disturb early infant/mother bonding or the developing toddler/mother relationship? ☐ Yes ☐ No If yes, please explain.

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___

Please describe the child **as an infant** (temperament, sleeping, eating patterns, etc.).

___

___

___

Ages at Milestones

Gross Motor: Crawled ______ Walked alone ________ Ran well ________________

Fine motor: Fed self with spoon ______ Scribbled _______ Tied shoes ________________________

Language: Used single words ______ Used sentences (2 or more words) ______________________

Described activity ____

Social/Adaptive: Potty trained/day ____

Potty trained/night ____

Rate of development overall: ☐ Slow ☐ Normal ☐ Fast

Medical History

Has the child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? ☐Yes ☐ No If yes, please describe the condition/injury, treatment, any surgery, when, how long, and where.

____

____

____

Has this child had any medical conditions or diagnoses? ☐ Yes ☐ No
If yes, please describe. ____

____

If the child had a head injury: Did he or she lose consciousness? ☐Yes ☐ No
How long?____

Was he or she comatose? ☐ Yes☐ No How long?_____________________________

Do you see the child as being ☐ Hyperactive? ☐ Inattentive? ☐ A behavior problem?

Does the child seem to be able to control his or her behavior and attention?
☐Yes ☐No Please explain.____

____

Has the child ever been diagnosed by a psychologist, physician, or other professional as having ADHD (Attention Deficit Hyperactivity Disorder)? ☐Yes ☐No

If yes, when?____

What treatment (**not medication**) has the child had for ADHD?______________________

____

Please describe any other handicapping conditions or special health considerations and their treatments.____

____

____

Date of last hearing test ___________ Were the results normal? ☐ Yes ☐ No
If no, please explain. ____

____

Please list medications (with dosage and times) currently being taken by the child, including nonprescription medications. ____

____

____

The child's current health is: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Current sleep patterns: ____

____

Please describe the child's appetite: ____

____

Does the child/adolescent have any sensitivities to certain foods, textures, sounds, or other sensory information? ☐ Yes ☐ No If yes, please describe. ____________________________

____

____

____

Behavioral and Mental Health History

Please describe any behaviors that are particularly concerning to you or others.

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____

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____

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments. ____

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____

Has the child had any previous psychological evaluations? ☐ Yes ☐ No If yes, when, where, and by whom?____

____

____

Has the child or family received any professional mental health treatment, such as individual or family counseling, group counseling, etc.? ☐ Yes ☐ No Please list any past and current treatments, including type of counseling, person counseled, names of participants, and length of treatment. ____

____

____

PRESENT PERSONALITY AND BEHAVIOR

Please circle all traits that apply to the child **now**:

Sad	Happy	Leader	Follower	Moody
Friendly	Quiet	Overactive	Independent	Dependent
Sensitive	Affectionate	Fearful	Cooperative	Tantrums
Lethargic	Too responsible	Trouble sleeping	Hard to discipline	Finicky
Even-tempered	Prefers to be alone			

What are the child/adolescent's strengths? ____

____

____

Educational History

Did the child attend preschool or daycare? ☐ Yes ☐ No If yes, list location, type of program, number of days per week, age when started, and progress. ______________________________

____

Current grade and school____

List previous schools and grades attended at each.____________________________________

____

____

Briefly describe the child's performance and any concerns in each grade:

Kindergarten____

1st Grade____

2nd Grade____

3rd Grade____

4th Grade____

5th Grade____

6th Grade____

Middle School____

High School____

Has the child/adolescent ever received any of the following? (check all that apply)

☐ Speech & Language Therapy ☐ Adaptive Physical Education

☐ Occupational Therapy ☐ Emotional/Behavioral services

☐ Physical Therapy

Has the child been placed in special education programs currently or in the past?

☐ Yes ☐ No

Category ______________________________

☐ Learning Disability (LD): Subjects ______________________________

☐ Language Disorder: Type ______________________________

☐ Tutoring: Subjects ______________________________

Social History

What does this child/adolescent like to do? (i.e., activities, hobbies, leisure time).

____

____

How much screen time (TV, computer, video games, electronics devices), on average, does the child/adolescent spend each day during the week __________ on weekends __________ during summer months ______________________________

How easily does this child/adolescent make friends?

☐ easier than average ☐ average ☐ worse than average ☐ don't know

Comments ______________________________

____

How long can this child/adolescent maintain a friendship?

☐ less than 6 mos. ☐ 6 mos.-1 yr. ☐ more than 1 yr. ☐ don't know

Comments ______________________________

____

Does your child/adolescent currently have a "best friend"?

☐ Yes ☐ No Group of friends? ☐ Yes ☐ No

Comments ______________________________

____

Additional Information

Please attach results of any previous psychological or educational testing.

Please add any additional comments you think might be helpful.

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Name:____ Relationship:____________________

Signature:_____________________________________ Date:__________________________