Developmental History

Child's Name: ____________________________

Person completing the form: ____________________________ Relationship: ____________________________

Medical History

Delivered at _________ weeks by (check one) ☐ Vaginal delivery ☐ Cesarean delivery

Complications during pregnancy: ________________________________________________________________

Complications during delivery: ________________________________________________________________

Birth weight: ____________________________

After delivery, did the child experience difficulty with any of the following?

☐ Breathing
  ☐ Respirator use for _________ days or _________ weeks

☐ Nursing or feeding
  ☐ Supplemented with formula
  ☐ Feeding tube
  ☐ Tongue tied
  ☐ Lip tied
  ☐ Weight loss

☐ Jaundice
  ☐ Use of bilirubin light for _________ days

☐ Seizures

☐ Birth defects
  ☐ Explain: ________________________________________________________________

Surgical History

Procedure: ____________________________ Date performed: ____________________________
Procedure: ____________________________ Date performed: ____________________________
Procedure: ____________________________ Date performed: ____________________________
Procedure: ____________________________ Date performed: ____________________________
Procedure: ____________________________ Date performed: ____________________________
Procedure: ____________________________ Date performed: ____________________________

Has your child had or have any of the following childhood illnesses:

☐ Measles
☐ Asthma
☐ Reflux
☐ Chicken Pox
☐ Mumps
☐ Rubella
☐ Scarlet Fever
☐ Tonsillitis
Ear Infections

Tubes in ears

Seizures

Meningitis

Other: ________________________________

Please provide any information about the indicated illnesses that would be important for staff to know:

____________________________________

Vision

Does your child have any issues with vision?  Yes □  No □

Date of most recent vision exam: ____________________________

Test results: ____________________________________________

Physician or clinic that performed the assessment: ____________________________

Hearing

Does your child have any issues with hearing?  Yes □  No □

Date of most recent hearing exam: ____________________________

Test results: ____________________________________________

Physician or clinic that performed the assessment: ____________________________

Medication

Does your child take medication on a regularly scheduled basis?  Yes □  No □

Please list all medications, the dosage and the purpose for the medication:

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<th>Medication</th>
<th>Dosage</th>
<th>Purpose</th>
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Developmental Milestones

At what age did your child perform the following:

Roll over: __________

Sit up: __________

Crawl: __________

Pull up: __________

Take first step: __________

Sleep through the night: __________

Smile: __________

Babble: __________

Say first word: __________
Begin toilet training: 
Master toilet training during the day: 
If not toilet trained please describe needs:

Social Milestones /History

Does your child appear to enjoy interactions with others? Yes □ No □ 
What behaviors or observations would lead you to this conclusion?

Name three activities you would consider your child’s favorites:
1. 
2. 
3. 

When your child is upset, how does he or she seek comfort?

Who are the most significant individuals in your child’s life and how much interaction do they have with your child?

Is there anything or any activities that cause fear or anxiety in your child?

Communication History

What is your child’s primary means of communication?

How does your child communicate wants and needs to you?

How does your child communicate wants and needs to those who are not familiar with their communication style?

Has your child ever received a speech and language evaluation? Yes □ No □
Who conducted the evaluation?

Did your child receive speech and language services after the evaluation? Yes [ ] No [ ]

For what length of time did your child receive speech and language services?

Developmental Assessments and Therapies

Has your child ever been evaluated for a developmental delay? Yes [ ] No [ ]

If yes, who conducted the evaluation? ________________________________

Did your child qualify for services for a developmental delay? Yes [ ] No [ ]

Please list all therapy services below:

Type of therapy: ________________________________ Dates: ______________

Therapist Name: ________________________________ Location: ______________

Phone Number: ________________________________

Do you have a report from this therapist that can be provided to ELC staff? Yes [ ] No [ ]

If no, can the ELC staff contact the therapist for a report? Yes [ ] No [ ]

Type of therapy: ________________________________

Therapist Name: ________________________________

Phone Number: ________________________________

Do you have a report from this therapist that can be provided to ELC staff? Yes [ ] No [ ]

If no, can the ELC staff contact the therapist for a report? Yes [ ] No [ ]

Type of therapy: ________________________________

Therapist Name: ________________________________

Phone Number: ________________________________

Do you have a report from this therapist that can be provided to ELC staff? Yes [ ] No [ ]

If no, can the ELC staff contact the therapist for a report? Yes [ ] No [ ]

Adaptive Equipment

Does your child utilize any of the following pieces of adaptive equipment?

- Hearing aid  [ ]
- Glasses  [ ]
- AFOs  [ ]
- Wheelchair  [ ]
- Walker  [ ]
- Special seating  [ ]
- Other: ________________________________  [ ]

- Other: ________________________________  [ ]