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: _____

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 take medication on a regularly scheduled basis? Yes ☐ No ☐
Please list all medications, the dosage and the purpose for the medication:

Medication	**Dosage**	**Purpose**

Developmental Milestones

At what age did your child perform the following:

Roll over: _____ Sleep through the night: _____
Sit up: _____ Smile: _____
Crawl: _____ Babble: _____
Pull up: _____ Say first word: _____
Take first step: _____

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: __________________________________ 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: __________________________________ 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 ☐

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

- ☐ Hearing aid
- ☐ Glasses
- ☐ AFOs
- ☐ Wheelchair
- ☐ Walker
- ☐ Special seating
- ☐ Other: __________________________________
- ☐ Other: __________________________________