



## 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



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Ear Infections

Tubes in ears

Seizures

Meningitis

Other: \_\_\_\_\_

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

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### 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:

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### **Social Milestones /History**

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

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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?

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

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

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### **Communication History**

What is your child's primary means of communication?

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How does your child communicate wants and needs to you?

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

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Has your child ever received a speech and language evaluation?      Yes      No



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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 RISE staff?      Yes                      No

If no, can the Rise 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 RISE staff?      Yes                      No

If no, can the Rise 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 RISE staff?      Yes                      No

If no, can the Rise 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: \_\_\_\_\_