Idaho Falls School District 91
A World Class Education

Developmental History

Child's name: _____Birthdate: _____ Date: _____

Information provided by:_____ Relationship: _____

Child is presently living with: ____ Natural Mother ____ Natural Father ____ Stepmother____
Stepfather ____ Adoptive Mother ____Adoptive Father ____ Foster Mother____ Foster Father____
Other (Specify) _____Siblings (Name and ages) _____
_____

What are your child's **needs** that lead you to this referral? _____

_____

What **concerns** if any do you have in the following developmental areas?

Learning: _____
Speech/Language: _____
Physical: _____
Social/Behavior: _____
Daily Living: _____

What are your child's **strengths** and preferred activities?

_____

Does your child **attend preschool or daycare**? **YES/NO** If **yes,** H**ow many hours per week?** _____

Daycare of Preschool Name: _____

Individual **suggestions** I have about working with my child: _____
_____

Any **other** information to help us better understand your child? (For example: cultural or religious life that might affect him/her at school, restrictions on any activities, recent changes at home): _____
_____
_____

Child's name: _____Birthdate: _____ Date: _____

Information provided by:_____ Relationship: _____

Developmental History Details – Please answer by circling YES or NO, then circling examples that apply or providing your information.		
Medical/Milestone/Daily Living: Birth weight _____Birth Place_____ Primary Physician Name_____ Age first rolled over _____, sat alone_____, pulled up_____, crawled _____, walked alone _____		
Full term pregnancy?	**YES / NO**	What week was child born?
Were there complications during pregnancy?	**YES / NO**	(infection, injury, illness, bleeding, toxemia, toxins such as drugs or alcohol) other:
Were there complications during delivery or hospital stay?	**YES / NO**	(resuscitation, needed oxygen, needed surgery, NICU, extended stay) other:
Has your child had serious illnesses, injury, hospitalization, chronic health problem, and /or restrictions due to a condition?	**YES / NO**	Please describe:
Medication taken on a regular basis?	**YES / NO**	Please list:
Has your child had a Well Child Check?	**YES / NO**	When: Results: By Whom:
Has your child had a **vision** screening?	**YES / NO**	By whom and when: Results:
Are you concerned about your child's **vision**?	**YES / NO**	(Failed vision screen, lost glasses, falls down a lot) other:
Has your child had a **hearing** test?	**YES / NO**	By whom and when: Results:
Are you concerned about your child's **hearing**?	**YES / NO**	(Failed hearing test, lost hearing aid, infections, tubes in ears), other:
Do you have concerns about your child's sleep?	**YES / NO**	If yes, what are your concerns?
Do you have concerns about your child's daily living skill? Is your child using utensils to eat?	**YES / NO** **YES/NO**	(Explain any problems with eating, bathing, dressing or learning to brush their teeth.)
Does your child help with any housework or chores?	**YES / NO**	Examples:
Is your child toilet trained?	**YES / NO**	
Developmentally similar to sibling or parent?	**YES / NO**	In what way?
Any period of failure to grow or unusual growth?	**YES / NO**	Explain.

Language and Learning: Age your child first talked (words), _____ talked (phrases), _____ talked in (sentences_____		
Does your child understand well?	**YES / NO**	
Does your child communicate well?	**YES / NO**	
Do others have difficulty understanding your child's speech?	**YES / NO**	(Who has difficulty understanding, what is their speech like, when as this first noticed, how does it affect daily living):
Is your child matching?	**YES / NO**	(Please circle: Colors, shapes, letters, numbers, animals) other:
Social/Behavioral:		
Does the family have concerns about the child's social skills and/or behavior?	**YES / NO**	What are the concerns?
Does your child have friendships?	**YES / NO**	(Some friends, plays with cousins, almost no friends, is isolated)
Does your child participate in activities outside of home?	**YES / NO**	(Religious groups, community organizations) other:
Does your child get along with other members of the household?	**YES / NO**	
Does your child respond well to positive discipline?	**YES / NO**	Explain:
Is your child receiving any therapy?	**YES / NO**	Name and location:
Are there any diagnoses of mental health conditions?	**YES / NO**	
Do you have support system(s) available to the family?	**YES / NO**	(Extended family, neighbors, friends, organizations)
Is there anything else you would like for us to know about your child?		