New England Learning & Diagnostic Center
Childhood Developmental History Form

1. Child and Respondent Information

Child full name:

Preferred name:

Date of birth:

Current age:

Grade / program:

School / setting:

Person completing form:

Relationship to child:

Best phone:

Email:

Interpreter needed? ☐ Yes ☐ No

Languages spoken at home:

Main concerns / reason for referral:

What are you hoping to learn or gain from the evaluation or visit?

2. Family, Living, and School Context

Who does the child live with:

Legal custody concerns or shared custody? ☐ Yes ☐ No

Number of moves in past 3 years:

People currently living in the home (name, age, relationship):

Major family stressors in the past 12 months:

School concerns, supports, or services:

3. Developmental Milestones

Milestone / Skill	Age Achieved	Notes / Concerns
Smiled responsively		
Sat without support		
Crawled		
Walked independently		
First words		
Two-word phrases		
Toilet trained (day)		
Toilet trained (night)		

4. Pregnancy, Birth, and Neonatal History

Pregnancy length:

Birth weight:

Birth parent age at delivery:

Delivery type:

Regular prenatal care? ☐ Yes ☐ No ☐ Unknown

Complications during labor/delivery? ☐ Yes ☐ No

If yes, describe complications, NICU stay, oxygen, jaundice, feeding problems:

Pregnancy exposures or illnesses? ☐ None known ☐ Yes ☐ Unknown

If yes, describe significant pregnancy factors:

5. Early Temperament, Feeding, Sleep, and Self-Care

Infant temperament described as: ☐ Easy ☐ Average ☐ Difficult ☐ Variable

Breast/formula/feeding history:

Early feeding problems? ☐ Yes ☐ No

Current sleep pattern / concerns:

Current self-care concerns? ☐ None ☐ Some ☐ Significant

Describe eating, dressing, bathing, brushing teeth, organization, independence:

6. Medical and Sensory History

Primary care clinician:

Current medical diagnoses, allergies, and medications:

History of surgery or hospitalization? ☐ Yes ☐ No

Important illnesses, injuries, surgeries, hospitalizations, seizures, head injuries, hearing/vision:

Sensory concerns present? ☐ No ☐ Yes

Describe sensory sensitivities or seeking behaviors:

7. Speech, Language, and Social Development

History of speech/language delay? ☐ Yes ☐ No ☐ Unsure

Describe communication skills:

Describe social development:

Any developmental regression or loss of skills? ☐ No ☐ Yes

If yes, when?

8. Motor, Attention, Learning, and Behavior

Motor history (balance, coordination, handwriting, fine motor, sports, fatigue, clumsiness):

Attention and executive functioning (distractibility, hyperactivity, impulsivity, transitions, planning):

Learning profile (reading, writing, spelling, math, listening comprehension, work pace, strengths):

Behavior and emotional regulation (tantrums, anxiety, mood, aggression, compliance, coping):

9. Family History

Family history of learning disability, ADHD, autism, language delay, anxiety, depression, etc.:

Family history of left-handedness / mixed-handedness:

10. Prior Evaluations and Services

Prior evaluations or therapy? ☐ Yes ☐ No

List prior evaluations, school testing, therapy, counseling, medication trials, etc.:

Current school-based services? ☐ Yes ☐ No

Describe IEP/504 eligibility, accommodations, related services, classroom placement:

11. Strengths and Interests

Child strengths, favorite activities, interests, talents, motivators, preferred ways of learning:

Anything else important for the clinician or reviewer to know:

Parent/Caregiver Signature

Date