NELDC
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DEVELOPMENTAL HISTORY QUESTIONNAIRE

Today's date:

DEMOGRAPHIC INFORMATION		
Name of person completing form:		Relationship to client:
Telephone: Home Work Mobile		Email:
Child's Name:	DOB:	Sex: ☐ M ☐ F ☐ Other
Street Address:	City:	State: Zip:
Is this location a: ☐ House ☐ Other: ☐ Apartment	Length of time at current address: years months	
Child's current school: Address:		Grade:
How did you hear about our practice? ☐ Doctor (Name): ☐ Internet (Site name):	☐ Print Media (Name): ☐ Other:	
Referral company: Address: City: State: Zip: Phone:		

Reason for Referral
What is the reason for your referral
How long have these learning/behavior difficulties been occurring?
In what setting(s) and how frequently do they occur?
Please rate their effect on your child's overall functioning: ☐ mild ☐ moderate ☐ severe ☐ none
What specific questions would you like to have answered?

PREGNANCY AND BIRTH

Were any of the following problems experienced during pregnancy?

☐ High/low blood pressure	☐ Anemia	☐ Excessive vomiting
☐ Dizziness/fainting	☐ Flu or colds	☐ Rh incompatibility
☐ Bleeding	☐ Unusually high/low weight gain	☐ Toxemia
☐ Emotional stress	☐ German measles	☐ Kidney infection
☐ Injury (please describe):	☐ Bed rest (please describe):	☐ Other (please describe):

Were any of the following used during pregnancy?

☐ Nicotine		Qty/Freq?	Duration?
☐ Alcohol		Qty/Freq?	Duration?
☐ Drugs	Type:	Qty/Freq?	Duration?
☐ OTC medications	Type:	Dose/Freq?	Duration?
☐ Prescription medication	Type:	Dose/Freq?	Duration?

Were fertilization techniques used to assist in conception? ☐ Yes ☐ No

Did the mother receive appropriate and adequate medical care? ☐ Yes ☐ No*

*If not, please explain:

Length of pregnancy (in weeks):	Hours of Labor:
Place of birth:	Was this the planned place of birth? ☐ Yes ☐ No

Please check all that apply

Delivery: ☐ Easy ☐ Normal ☐ Difficult Complications:
☐ Vaginal ☐ Induced ☐ Cesarean
☐ Breech ☐ Jaundice ☐ Forceps/suction used

Birth weight: lb(s) oz(s)	Apgar scores:
Length of stay: Mother Child	Was the child placed in the NICU? ☐ Yes * ☐ No

*Why?

Additional comments:

DEVELOPMENT

Please indicate the age at which your child reached the following developmental milestones (If unsure of the exact age, please give your best estimate. If the child has not yet reached the milestone, leave blank):

Language

First word: 2-word phrases: Sentences:

Motor

Crawl: Walk: Run: Throw a ball:
Tie shoes: Ride a bike:

Self-Care

Toilet trained—urine*: Toilet trained—bowel: Dress self: Bathe self:
Stay home alone: Cross street safely:

*Accidents? ☐ Yes** ☐ No *Accidents? ☐ Yes** ☐ No

**Frequency? **Frequency?

Has there been any regression or loss of previously learned skills? ☐ Yes ☐ No
If yes, please explain:

MEDICAL HISTORY

Please indicate whether the child has ever experienced the following difficulties or illnesses:

☐ Anemia	☐ Feeding disorder	☐ Leukemia
☐ Asthma	☐ Fevers above 104° F	☐ Loss of consciousness
☐ Bruising easily	☐ Frequent colds	☐ Lyme Disease
☐ Cancer	☐ Frequent diarrhea	☐ Measles
☐ Chicken Pox	☐ Frequent ear infections	☐ Meningitis
☐ Chronic cough	☐ Frequent headaches	☐ Mumps
☐ Concussion	☐ Frequent/intense stomach pain	☐ Muscle pain
☐ Constipation	☐ Frequent sinus infections	☐ Pain/strong odor while urinating
☐ Diabetes	☐ Frequent sore throats	☐ Pneumonia
☐ Dizziness	☐ Frequent/unexplained rashes	☐ Seizures
☐ Eczema	☐ Frequent/unexplained sores	☐ Shortness of breath
☐ Excessive vomiting	☐ Heart condition	☐ Sleep apnea
☐ Excessive sleepiness/fatigue	☐ Kidney disorder	☐ Thyroid disorder
☐ Exposure to mold	☐ Lead poisoning	☐ Urinary tract infection
☐ Other:		

Has the child suffered from any other lengthy illness? ☐ Yes* ☐ No
*If yes, please describe:

Has the child suffered a head injury? ☐ Yes* ☐ No
*Please describe:

Has the child undergone any operative procedures? ☐ Yes* ☐ No
*Procedure(s) and date(s):

Does the child have a genetic disorder? ☐ Yes* ☐ No
*Which one?

Has the child received all of his/her immunizations? ☐ Yes ☐ No*
*Which ones were not given, and why?

Were there any adverse reactions to immunizations? ☐ Yes* ☐ No
*Please explain:

When was the child's last audiological (hearing) exam? Was it normal? ☐ Yes ☐ No

When was the child's last vision exam? Was it normal? ☐ Yes ☐ No

Please indicate any allergies (include foods, medications, animals, environmental, etc.):

Please indicate all current medications:

Medication Name	Dosage	Reason for Use
1.		
2.		
3.		
4.		

Pediatrician name: Address: Phone:

FAMILY/HOUSEHOLD

Caregiver 1:	Caregiver 2:
Full name:	Full name:
Age: Sex: ☐M ☐F	Age: Sex: ☐ M ☐ F
Occupation	Occupation:
Highest level of education completed: ☐ High School ☐ College ☐ Master's ☐ Doctorate	Highest level of education completed: ☐ High School ☐ College ☐ Master's ☐ Doctorate
Primary language ☐ English ☐ Other:	Primary language: ☐English ☐ Other:
Living in child's home? ☐ Yes ☐No	Living in child's home? ☐ Yes ☐ No

Caregivers' current marital status:	Caregiver 1:	Caregiver 2:
☐ married to each other	☐ remarried times	☐remarried times
☐ separated for years*	☐ involved with someone	☐ involved with someone
☐ divorced for years*	☐ deceased for years	☐ deceased for years
	age of child at mother's death:	age of child at father's death:

*Who has custody of the child? ☐ Caregiver 1 ☐ Caregiver 2 ☐ joint ☐ other:
Frequency of contact with the other parent?

Other adults frequently involved in parenting the child:

	Name	Age	Relationship to child	Occupation	Education
1.					
2.					

Siblings:

	Name	Age	Grade/Occupation	Lives in child's home?	Get along with child?
1.				☐ Yes ☐ No	☐ Yes ☐ No
2.				☐ Yes ☐ No	☐ Yes ☐ No
3.				☐ Yes ☐ No	☐ Yes ☐ No
4.				☐ Yes ☐ No	☐ Yes ☐ No
5.				☐ Yes ☐ No	☐ Yes ☐ No

Describe the home environment:
☐ Outstanding home environment
☐ Normal home environment
☐ Chaotic home environment
☐ Witnessed physical/verbal/sexual abuse toward others
☐ Experienced physical/verbal/sexual abuse from others

Additional comments:

SOCIAL/EMOTIONAL/BEHAVIORAL

Please indicate whether the child has ever experienced difficulties in the following areas:
(C = Current difficulties; H = History of previous difficulties)

C	H		C	H	
☐	☐	Difficulty making friends	☐	☐	Frequent/excessive crying
☐	☐	Difficulty maintaining friendships	☐	☐	Short attention span
☐	☐	Fights with friends	☐	☐	Easily over-stimulated
☐	☐	Prefers to play alone	☐	☐	Overly energetic
☐	☐	Uncomfortable with new people	☐	☐	Easily distracted
☐	☐	Plays mostly with younger children	☐	☐	Poor concentration
☐	☐	Aggressive/assaults others	☐	☐	Lack of self-control
☐	☐	Gets angry/disappointed by friends easily	☐	☐	Hyperactive
☐	☐	Cruel to other children	☐	☐	Impulsive
☐	☐	Distrustful of others	☐	☐	Frequently disobedient
☐	☐	Poor empathy	☐	☐	Breaks things
☐	☐	Speech and language difficulties	☐	☐	Chronic lying
☐	☐	Repeats words of others	☐	☐	Stealing
☐	☐	Unusual vocal intonation	☐	☐	Not trustworthy
☐	☐	Lack of attachment	☐	☐	Self-injurious behaviors or threats
☐	☐	Poor eye contact	☐	☐	Violent temper
☐	☐	Immature	☐	☐	Cruel to animals
☐	☐	Excessive fears/worries	☐	☐	Fire setting
☐	☐	Biting nails	☐	☐	Bizarre behavior
☐	☐	Grinding teeth	☐	☐	Alcohol use
☐	☐	Indecisive	☐	☐	Drug use
☐	☐	Banging head	☐	☐	Tics/twitches
☐	☐	Tantrums: Frequency Duration	☐	☐	Eating difficulties
☐	☐	Overreacts to problems	☐	☐	Sleep difficulties
☐	☐	Severe irritability	☐	☐	Colic as an infant
☐	☐	Hostile/angry mood	☐	☐	Sensory sensitivity (e.g., sound, clothing)
☐	☐	Often sad	☐	☐	Other:

Current psychiatric diagnoses:

Please list all current and previous outpatient therapists:

Name	Address	Phone	Diagnosis	Dates seen
1.				
2.				
3.				

Has the child ever received inpatient therapy? ☐ Yes* ☐ No
*Please describe, including facility name, dates, and reason for treatment:

Psychiatrist's name and address:

Is there a family history of any of the following psychiatric disorders?

☐ ADHD	☐ Autism/Asperger's	☐ Drug abuse/addiction	☐ Schizophrenia
☐ Alcoholism	☐ Bipolar Disorder	☐ Obessive-Compulsive	☐ Other:
☐ Anxiety	☐ Clinical Depression	☐ Phobia	

If yes to any of the above disorders please write the name of the disorder and the relationship to the child below:

ACADEMICS

Did/does the child attend preschool? ☐ Yes * ☐ No *At what ages?

Did this child have any difficulty transitioning to preschool or kindergarten?

If there were any problems observed or reported in school, please describe:

Has the child been retained? ☐ Yes* ☐ No
*Which grade and why?

Has the child skipped a grade? ☐ Yes* ☐ No
*Which grade and why?

Does the child have a history of special education? ? ☐ Yes ☐ No

Has the child ever had an IEP? ☐ Yes ☐ No Is it current? ? ☐ Yes ☐ No

Has the child ever been on a 504 Plan? ☐ Yes ☐ No Is it current? ? ☐ Yes ☐ No

Has the child ever been suspended or expelled from school? ? ☐ Yes* ☐ No
*Please explain:

What are the child's strongest subjects?

What are the child's weakest subjects?

Have these changed over time? ? ☐ Yes* ☐ No
*How so?

Does the child have a history of frequent absence from school? ? ☐ Yes* ☐ No
*Please explain:

ADDITIONAL INFORMATION

Please list any additional treatment providers who currently or previously have seen the child:

Name	Address	Phone	Dates Seen	Provider Type
1.				
2.				
3.				
4.				

Additional information relevant to the evaluation process/additional comments: