Monocacy
Neurodevelopmental Center

65 THOMAS JOHNSON DRIVE, SUITE A, FREDERICK, MD 21702

Young Child Developmental History Form

Please fill out this questionnaire as completely as possible.
All information is confidential and will be protected in accordance with State and Federal law.

Client Name: _____ **Date**: _____

Information supplied by (name and relationship to the client): _____

Client's full legal name: _____ Birth date: _____ Age: _____

Client's current residence (list parent or other names and % if more than one home):

_____

Preferred nickname: _____ Handedness: ☐ Left or ☐ Right

Sex: M F Gender: _____ Ht: _____ Wt: _____ Birthplace: _____

Ethnic identification: _____ Grade in school: _____

Primary language: _____ Other languages spoken: _____

First Parent/Guardian Name: _____ Status: Mother ___ Father ___ Other: _____ Biological parent? ☐ Yes ☐ No Adoptive parent? ☐ Yes ☐ No Stepparent? ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced Primary Language: _____ Secondary Language: _____ Address: ☐ (same as child): _____ City: _____ State: _____ Zip code: _____ Education: _____ Employer: _____ Occupation: _____ Shift: _____ Telephone number(s): _____ Year deceased (if applicable): _____	Second Parent/Guardian Name: _____ Status: Mother ___ Father ___ Other: _____ Biological parent? ☐ Yes ☐ No Adoptive parent? ☐ Yes ☐ No Stepparent? ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced Primary Language: _____ Secondary Language: _____ Address: ☐ (same as child): _____ City: _____ State: _____ Zip code: _____ Education: _____ Employer: _____ Occupation: _____ Shift: _____ Telephone number(s): _____ Year deceased (if applicable): _____
Third Parent/Guardian Name: _____ Status: Mother ___ Father ___ Other: _____ Biological parent? ☐ Yes ☐ No Adoptive parent? ☐ Yes ☐ No Stepparent? ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced Primary Language: _____ Secondary Language: _____ Address: ☐ (same as child): _____ City: _____ State: _____ Zip code: _____ Education: _____ Employer: _____ Occupation: _____ Shift: _____ Telephone number(s): _____ Year deceased (if applicable): _____	Fourth Parent/Guardian Name: _____ Status: Mother ___ Father ___ Other: _____ Biological parent? ☐ Yes ☐ No Adoptive parent? ☐ Yes ☐ No Stepparent? ☐ Yes ☐ No Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced Primary Language: _____ Secondary Language: _____ Address: ☐ (same as child): _____ City: _____ State: _____ Zip code: _____ Education: _____ Employer: _____ Occupation: _____ Shift: _____ Telephone number(s): _____ Year deceased (if applicable): _____

Is this client adopted? ☐ Yes ☐ No If yes does the client know? ☐ Yes ☐ No Age at adoption: _____

Alternate Contacts
Emergency contact: _____
Telephone number: _____ Relationship: _____

Who has <u>legal</u> custody of the client?

Name: _____ ☐ Temporary ☐ Permanent ☐ Sole ☐ Shared

Name: _____ ☐ Temporary ☐ Permanent ☐ Sole ☐ Shared

Who has <u>physical</u> custody of the client?

Name: _____ ☐ Temporary ☐ Permanent ☐ Sole ☐ Shared

Name: _____ ☐ Temporary ☐ Permanent ☐ Sole ☐ Shared

Please provide details physical custody and visitation agreement, and of any change in custody/residence:
_____
_____
_____

Family and Home Information: (provide additional information as needed)

Home #1: All additional persons currently living in the household:

Name	Age	Gender	Grade/Education level	Relationship

Home #2: All additional persons currently living in the household:

Name	Age	Gender	Grade/Education level	Relationship

If the client has a parent not living with the client, are there visitations? ☐ Yes ☐ No
Details: _____

Names and ages of other siblings not living with the client: _____
_____

Childcare provider(s) names and details (days and times) _____
_____

Does anyone in the client's family have a psychiatric illness (behavioral or emotional)? ☐ Yes ☐ No
Does anyone in the client's family haver a developmental or learning disorder? ☐ Yes ☐ No
Does anyone in the client's family had a seizure disorder? ☐ Yes ☐ No
Does anyone in the client's family have a substance abuse problem? ☐ Yes ☐ No
If yes to any of these questions, please provide details: _____
_____
_____
_____

If the client's residence is troubled by domestic violence,
or if the client ever been physically, sexually or emotionally abused please provide additional information at intake.

Client Developmental History: Please complete as much of the following about the client as possible:

Number of pregnancies of mother: _____ Which one was this client?: _____

Were there any complications during pregnancy? ☐ No ☐ Yes ☐ Don't Know If "yes," please explain:

_____

_____

_____

_____

_____

_____

Number of Weeks Gestation _____

Delivery ☐ Vaginal ☐ Forceps ☐ Suction ☐ Caesarean section ☐ Breech

Were there any problems during delivery? ☐ No ☐ Yes

If "yes," please explain: _____

_____

_____

_____

_____

Birth weight: _____ Condition at birth? Please explain (e.g. apgar scores, etc): _____

_____

_____

_____

_____

Incubator? ☐ No ☐ Yes If yes how long? _____

Jaundiced: Bilirubin Lights? ☐ No ☐ Yes If yes how long? _____

Breathing Problems right after birth? ☐ No ☐ Yes Details: _____

Supplemental Oxygen ☐ No ☐ Yes If yes, how long? _____

Total number of Days Client was in hospital after birth: _____

Infancy-Toddler Period:

A. Were there any feeding problems? ☐ No ☐ Yes
   If "yes," please explain: _____
B. Did your client sleep well? ☐ No ☐ Yes
   If "no," please explain: _____
C. At what age was your client toilet trained? _____
   Were there any difficulties? _____
D. Describe you client's temperament during the first 12 months: _____
   _____
E. Did your client like to be held? ☐ No ☐ Yes
F. Could your client entertain him/herself? ☐ No ☐ Yes
G. Did the client have problems with frequent head banging? ☐ No ☐ Yes
H. Did the client have an excessive number of accidents? ☐ No ☐ Yes
I. Was the client overly absorbed with stimuli? ☐ No ☐ Yes (please list _____)

Milestones
Was the client's development in the following areas early, normal or delayed (list ages if known):

	EARLY	NORMAL	DELAYED
Wean			
Sit Alone			
Roll Over			
Stand Alone			
Walk by Self			
Dress Self (except for buttons and tying knots)			
Feed self with spoon or fork			
Spoke first words (other than Mama/Dada)			
Spoke first real sentences			
Become bladder trained (infrequent daytime accidents)			
Become nighttime trained (rare accidents)			
Become bowel trained (no accidents)			
Help with household tasks			
Ride a bicycle			
Tie own shoes			

Any difficulties with above? ☐ No ☐ Yes Details: _____
_____
_____
_____

Client's Medical History:
Has the client had any serious: Accidents? ☐ No ☐ Yes Injuries? ☐ No ☐ Yes Illnesses? ☐ No ☐ Yes
If yes, please give details: _____
_____
_____

Please detail any of the client's hospitalizations:

Date	Age	Hospital	Reason	Length of stay

Client's Physician: _____ Phone: _____
Name of Medical Group: _____
Date of last hearing screening _____ Location _____ Hearing Aids ☐ No ☐ Yes
Date of last vision screening _____ Location _____ Glasses ☐ No ☐ Yes
If glasses, what for _____
Does or did the client have lead poisoning? ☐ No ☐ Yes
If "yes," please explain: _____

Past and Current Medications taken by the client:

Date	Age	Drug	Reason	Physician

Health Concerns:

Respiratory

Frequent Colds	☐ No	☐ Yes	Details: _____
Chronic Cough	☐ No	☐ Yes	Details: _____
Asthma	☐ No	☐ Yes	Details: _____
Hay Fever	☐ No	☐ Yes	Details: _____
Sinus Condition	☐ No	☐ Yes	Details: _____

Cardiovascular

Shortness of Breath or Dizziness with Physical Exertion	☐ No	☐ Yes	Details: _____
Activity Limitation Due to Heart Condition	☐ No	☐ Yes	Details: _____
Heart Murmur	☐ No	☐ Yes	Details: _____

Gastrointestinal

Excessive Vomiting	☐ No	☐ Yes	Details: _____
Frequent Diarrhea	☐ No	☐ Yes	Details: _____
Constipation	☐ No	☐ Yes	Details: _____
Stomach Pain	☐ No	☐ Yes	Details: _____

Genitourinary

Urination in Pants/ Bed	☐ No	☐ Yes	Details: _____
Pain While Urinating	☐ No	☐ Yes	Details: _____

Musculoskeletal

Muscle Pain	☐ No	☐ Yes	Details: _____
Clumsy Walk	☐ No	☐ Yes	Details: _____
Poor Posture	☐ No	☐ Yes	Details: _____

Skin

Frequent Rashes	☐ No	☐ Yes	Details: _____
Bruises Easily	☐ No	☐ Yes	Details: _____
Sores	☐ No	☐ Yes	Details: _____
Severe Acne	☐ No	☐ Yes	Details: _____
Itchy Skin (Eczema)	☐ No	☐ Yes	Details: _____

Neurological

Seizures/ Convulsions	☐ No	☐ Yes	Details: _____
Speech Defects	☐ No	☐ Yes	Details: _____
Accident Prone	☐ No	☐ Yes	Details: _____
Grinds Teeth	☐ No	☐ Yes	Details: _____
Has tics/twitches	☐ No	☐ Yes	Details: _____
Bangs Head	☐ No	☐ Yes	Details: _____
Rocks Back and Forth	☐ No	☐ Yes	Details: _____

Allergies

Allergies to Medicine	☐ No	☐ Yes	Details: _____
Allergies to Food	☐ No	☐ Yes	Details: _____
Other Allergies	☐ No	☐ Yes	Details: _____

Speech

Stuttering	☐ No	☐ Yes	Details: _____
Unclear Speech	☐ No	☐ Yes	Details: _____
Other speech problems	☐ No	☐ Yes	Details: _____

Hearing

Severe Ear Infections	☐ No	☐ Yes	Details: _____
Hearing Problems	☐ No	☐ Yes	Details: _____
Ear Tubes	☐ No	☐ Yes	Details: _____

(If yes, number of times: _____)

Family Medical History

Is there a history of any of the following in the family (Use "M" for mother's side; "F" for father's side.)

_____	TB	_____	Vision problems
_____	Birth defects	_____	Hearing problems
_____	Emotional problems	_____	Drugs
_____	Behavior problems	_____	Alcohol
_____	Intellectual Disability	_____	Diabetes
_____	Goiter (Thyroid)	_____	Convulsions/seizures
_____	Other	_____	Other

Further comments (attach additional information as needed):: _____

Client's Assessment and Treatment History: Please include as complete a history as possible or past and current evaluations and treatment. Include agencies, physicians, counselors, institutions, therapists, etc. Also include information about early intervention services (e.g. IFSP).

Provider	Dates (From/To):	Type of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the client been court involved? ☐ No ☐ Yes If "yes," please explain: _____

Client Educational History: Current School: _____ Grade: _____

	Date	Location	Problems (Y/N)	Reason for leaving
Preschool	_____	_____	_____	_____
Kindergarten	_____	_____	_____	_____

Has the client experienced any of the following in school?
☐ Learning Problems ☐ Discipline Problems ☐ Social Problems ☐ Attention Problems ☐ Emotional Problems

If you answered, "yes," to problems at any academic level, please detail here:

_____

_____

_____

Has the client ever an IEP or 504 plan? ☐ No ☐ Yes If yes, please provide a copy of most recent IEP/504 plan.
Has there been academic/psychological testing done at school ☐ No ☐ Yes? If yes, please provide a copy of most recent

Daily Routines and Social Interactions:
Does the client eat breakfast ☐ Yes ☐ No If so, who prepares it? _____
What does the client do after school? _____
Does the family eat dinner together? ☐ Yes☐ No
Are there any problems during dinner? ☐ Yes ☐ No, If yes, describe: _____
_____
Are there any problems with bedtime routines? ☐ Yes ☐ No, If yes, describe _____
_____
Does the client spend time with friends? ☐ Yes ☐ No How much time on a weekly basis? _____
How many friends does you child have? _____

Problem Checklist

	NOT A PROBLEM	SOMEWHAT A PROBLEM	A PROBLEM	A SEVERE PROBLEM
PROBLEMS WITH SLEEPING				
Trouble Sleeping	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐
Sleep walking	☐	☐	☐	☐
Sleep talking	☐	☐	☐	☐
SCHOOL PROBLEMS				
Is afraid to go to school	☐	☐	☐	☐
Won't obey school rules	☐	☐	☐	☐
Has conflicts with teachers	☐	☐	☐	☐
RELATIONSHIPS WITH PEERS				
Has few or no friends	☐	☐	☐	☐
Plays alone most of the time	☐	☐	☐	☐
Fights with others	☐	☐	☐	☐
Tries to boss others around	☐	☐	☐	☐
Blames others	☐	☐	☐	☐
BEHAVIOR PROBLEMS				
Tantrums	☐	☐	☐	☐
Lies	☐	☐	☐	☐
Steals	☐	☐	☐	☐
Breaks things	☐	☐	☐	☐
Assaultive	☐	☐	☐	☐
Other:	☐	☐	☐	☐
COMMUNICATION SKILLS				
Limited Speech	☐	☐	☐	☐
Repetitive Speech Problems	☐	☐	☐	☐
Regression in Speech	☐	☐	☐	☐
SOCIAL SKILLS				
Makes poor eye contact	☐	☐	☐	☐
Afraid of many things	☐	☐	☐	☐
Very Shy	☐	☐	☐	☐
Demands too much attention	☐	☐	☐	☐
Plays Alone				
Withdraws from people	☐	☐	☐	☐
EMOTIONAL PROBLEMS				
Has unreasonable fears				
Is sad or unhappy most times	☐	☐	☐	☐
Cries a lot	☐	☐	☐	☐
Sluggish or Slow	☐	☐	☐	☐
Tired most of the time	☐	☐	☐	☐
Mood changes quickly	☐	☐	☐	☐
ATTENTION AND SELF-CONTROL				
Has difficulty concentrating	☐	☐	☐	☐
Is easily distracted	☐	☐	☐	☐
Can't sit still	☐	☐	☐	☐
Hyperactive	☐	☐	☐	☐

OTHER				
Says or does strange things	☐	☐	☐	☐
Displays repetitive/odd behaviors	☐	☐	☐	☐
Hurts Self (how_____)	☐	☐	☐	☐
Bites nails	☐	☐	☐	☐
Not fully bladder trained	☐	☐	☐	☐
Not fully bowel trained	☐	☐	☐	☐
Has aches and pains	☐	☐	☐	☐
Clumsy and accident prone	☐	☐	☐	☐

Please describe other problems: _____

What behavior distresses you the most? _____

What do you think are the child's greatest strengths? _____

Please describe the changes you hope to see in the child as a result of our work:

Completed by: _____

Signature: _____ Date: _____