MONOCACY Start CENTER

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

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): _____

Presenting problem(s): _____

Client's Information

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

Client's current residence: ☐ With biological parents ☐ Father ☐ Mother ☐ Other: _____

If "other," please give address: _____

Preferred nickname: _____ Handedness: ☐ Left or ☐ Right

Gender: M F Age: _____ Ht: _____ Wt: _____

Hair color: _____ Eye color: _____ Birthplace: _____

Ethnic identification: _____ Year in school: _____

Primary language: _____ Other languages spoken: _____

Parents' Information

Father's name: _____ Birth date: _____

Biological parent? _____ No _____ Yes

Stepfather? ____No ____ Yes

Highest Grade Completed: _____

Primary Language: _____

Secondary Language: _____

Address: ☐ (same as child): _____

City: _____ State: _____ Zip code: _____

Employer: _____

Occupation: _____

Shift: _____

Telephone number: _____

Year deceased (if applicable): _____

Mother's name: _____ Birth date: _____

Biological parent? _____ No _____ Yes

Stepmother? _____ No _____Yes

Highest Grade Completed _____

Primary Language _____

Secondary Language _____

Address: ☐ (same as child): _____

City: _____State:_____ Zip code: _____

Employer: _____

Occupation: _____

Shift: _____

Telephone number: _____

Year deceased (if applicable): _____

Alternate Contacts

Emergency contact: _____

Telephone number: _____ Relationship: _____

Parents' Marital Status

Mother: ☐ Married to patient's father ☐ Separated ☐ Divorced ☐ Remarried ☐ Single ☐ Deceased

Father: ☐ Married to patient's mother ☐ Separated ☐ Divorced ☐ Remarried ☐ Single ☐ Deceased

Custody and Legal School District of Residence

Who has legal custody of the client? Name: _____

☐ Temporary ☐ Permanent

Address: _____

City: _____State: ____ Zip code: _____

Telephone number: _____County: _____

If the Department of Social Services has custody (i.e., foster care placement), indicate the name and address of the parents at the time that the department took custody and the caseworker:

Parent's name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Telephone number: _____ County: _____
School district: _____
Caseworker: _____
Telephone number: _____ County: _____

Family and Home Information:

All additional persons currently living in the household:

Name	Birth date	Sex	Education level	Relationship

Natural parent(s) who do not live in the household:

Name	Birth date	Sex	Education level	Relationship

Has the client lived with both parents since birth? ☐ No ☐ Yes

If "no," list changes chronologically (include residential placements).

From: (Dates preferred, or client's age).	To:	Child lived with:

If the client is not living with both parents, please list reason:

☐ Parents separated ☐ Parents divorced ☐ Parent deceased ☐ Other

If "other," please explain: _____

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

How frequently: _____

Reason: _____

If there are any other children living in the family:

A. Do any of them have physical or emotional problems? ☐ No ☐ Yes
   If "yes," please explain: _____

B. If "yes," have they received counseling or other forms of help? ☐ No ☐ Yes
   If "yes," please explain: _____

Is your house troubled by domestic violence? ☐ No ☐ Yes

If "yes," please explain: _____

Does any family member have an alcohol or drug problem? ☐ No ☐ Yes

If "yes," please explain: _____

Has anyone in the client's family had a psychiatric illness? □ Yes □ No
If yes, who and were they hospitalized? _____
Has anyone in the client's family attempted suicide? □ Yes □ No
If yes, who? _____
Has anyone in the client's family had a seizure disorder? □ Yes □ No
If yes, who? _____
Has anyone in the client's family had a problem with or treated for substance abuse problem? □ Yes □ No
If yes, who? _____
Has the client ever been physically, sexually or emotionally abuse? □ Yes □ No
Has the client ever had previous psychiatric treatment, counseling or therapy? □ Yes □ No
If yes, where were they hospitalized? _____
□ Inpatient □ Outpatient
Describe the results of past treatment and the reason for terminating treatment: _____
_____
_____

Child Care

If primary caregivers work outside the home, please provide the following information.

Who cares for this client when caregivers are gone? _____
How many hours per day is this client in a child-care setting? _____
How many different people care for this client? (Please explain.) _____

Client Developmental History

Has the client had any serious illness? □ Yes □ No
Has the client had any head injuries? □ Yes □ No
Is the client on medication at this time? □ Yes □ No
Please complete as much of the following about the client as possible:

Is this client adopted? □ Yes □ No If yes, at what age? _____ If yes does the client know? □ Yes □ No

Number of pregnancies of mother: _____ Which one was this client?: _____
During pregnancy, did this client's mother:

Have high blood pressure? □ Yes □ No □ Don't Know
Have diabetes or sugar in urine? □ Yes □ No □ Don't Know
Have kidney problems or protein in urine? □ Yes □ No □ Don't Know
Have German measles? □ Yes □ No □ Don't Know
If yes when? _____
Drink alcoholic beverages? □ Yes □ No □ Don't Know
About how much? _____
Use any medications? □ Yes □ No □ Don't Know
Have hormone pills or injections? □ Yes □ No □ Don't Know

Take any medications? □ Yes □ No □ Don't Know
If yes, what? _____
Have recurrent emotional problems? □ Yes □ No □ Don't Know
Bleeding? □ Yes □ No □ Don't Know
If yes, when? _____
Frequently smoke cigarettes? □ Yes □ No □ Don't Know
If yes how much? _____
Have a drug dependency? □ Yes □ No □ Don't Know
Other: _____

Were there any prenatal problems during pregnancy? ☐ No ☐ Yes
If "yes," please explain: _____
_____
_____

Were there any problems during delivery? ☐ No ☐ Yes
If "yes," please explain: _____
Birth weight: _____ lbs _____ oz.
Weeks Gestation _____

Was delivery: □ Difficult? □ Easy? □ Slow? □ Quick?
□ Caesarean section □ Breech □ Forceps □ Suction
Other complications: _____

Condition at birth? Please explain (e.g. apgar scores, needed to be revived, have yellow jaundice, need oxygen):

_____
_____
_____
_____

Incubator? ☐ No ☐ Yes If so how long? _____
Jaundiced: Bilirubin Lights? ☐ No ☐ Yes If yes how long? _____
Breathing Problems right after birth: Describe? _____
Supplemental Oxygen ☐ No ☐ Yes If yes, how long? _____
Total number of Days Baby was in hospital: _____

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 tricycle			
Ride a bicycle			
Tie own shoes			

Any difficulties with above? _____

Client's Medical History:

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: _____

Please detail any of the client's hospitalizations:

Date	Age	Hospital	Reason	Length of stay

Please detail any medication history:

Date	Age	Drug	Reason	Physician

Respiratory

Frequent Colds	No ___ Yes ___	Hay Fever	No ___ Yes ___
Chronic Cough	No ___ Yes ___	Sinus Condition	No ___ Yes ___
Asthma	No ___ Yes ___		

Cardiovascular

Shortness of Breath or Dizziness with Physical Exertion	No ___ Yes ___
Activity Limitation Due to Heart Condition	No ___ Yes ___
Heart Murmur	No ___ Yes ___

Gastrointestinal

Excessive Vomiting	No ___ Yes ___	Constipation	No ___ Yes ___
Frequent Diarrhea	No ___ Yes ___	Stomach Pain	No ___ Yes ___

Genitourinary

Urination in Pants/ Bed	No ___ Yes ___	Pain While Urinating	No ___ Yes ___

Musculoskeletal

Muscle Pain	No ___ Yes ___	Poor Posture	No ___ Yes ___
Clumsy Walk	No ___ Yes ___		

Skin

Frequent Rashes	No ___ Yes ___	Severe Acne	No ___ Yes ___
Bruises Easily	No ___ Yes ___	Itchy Skin (Eczema)	No ___ Yes ___
Sores	No ___ Yes ___		

Neurological

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

Allergies

Allergies to Medicine	No ___ Yes ___	Allergies to Food	No ___ Yes ___
_____		_____	
_____		_____	
Other Allergies	No____ Yes ____		

Speech

Stuttering	No ___ Yes ___	Other speech problems	No ___ Yes ___
Unclear Speech	No ___ Yes ___		

Hearing

Severe Ear Infections No ___ Yes ___ Ear Tubes No ___ Yes ___

Hearing Problems No ___ Yes ___ (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: _____

_____

Client Treatment History

Has the client ever received ABA therapy? __Y __N If yes, please provide the following details:

Start	End	Hours/Week	Provider
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please include (chronologically if possible) as complete a history as possible. Include agencies, physicians, counselors, institutions, therapists, etc.

Date	Age	Contact person	Services provided	Length of involvement
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has the client been court involved? ☐ No ☐ Yes

If "yes," please explain: _____

_____

Client Educational History:

Current School: _____ Grade: _____

Primary Teacher (grades K to 5): _____

		Date	Location	Problems (Y/N)	Reason for leaving
Preschool		_____	_____	_____	_____
Kindergarten		_____	_____	_____	_____
Grade	1	_____	_____	_____	_____
	2	_____	_____	_____	_____
	3	_____	_____	_____	_____
	4	_____	_____	_____	_____
	5	_____	_____	_____	_____
	6	_____	_____	_____	_____
	7	_____	_____	_____	_____

8				
9				
10				
11				
12				

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. Please give any information about treatment (if any) provided by the school at the time of occurrence:

_____

_____

_____

Has the client ever an IEP or 504 plan? __Y __N
If yes, please provide dates of services/accommodations and a copy of most recent IEP/504 plan.

Has there been any academic or psychological testing done at school or elsewhere? ☐ Yes ☐ No
If yes, what type of testing? _____When: _____
What have been the client's usual report card grades? _____
What have been the client's most recent grades? _____

Please circle the number which best describes the client on each particular problem.

	NOT A PROBLEM	SOMEWHAT A PROBLEM	A PROBLEM	A SEVERE PROBLEM
PROBLEMS WITH SLEEPING				
Trouble Sleeping	**1**	**2**	**3**	**4**
Nightmares	**1**	**2**	**3**	**4**
Sleep walking	**1**	**2**	**3**	**4**
Sleep talking	**1**	**2**	**3**	**4**
SCHOOL PROBLEMS				
Has problems learning in school	**1**	**2**	**3**	**4**
Is afraid to go to school	**1**	**2**	**3**	**4**
Won't obey school rules	**1**	**2**	**3**	**4**
Often skips school	**1**	**2**	**3**	**4**
Has conflicts with teachers	**1**	**2**	**3**	**4**
Performs below his/her ability	**1**	**2**	**3**	**4**
RELATIONSHIPS WITH PEERS				
Picks on others	**1**	**2**	**3**	**4**
Has few or no friends	**1**	**2**	**3**	**4**
Is called weird by others	**1**	**2**	**3**	**4**
Plays alone most of the time	**1**	**2**	**3**	**4**
Fights with others	**1**	**2**	**3**	**4**
Hangs around with bad crowd	**1**	**2**	**3**	**4**
Tries to boss others around	**1**	**2**	**3**	**4**
Blames others	**1**	**2**	**3**	**4**

BEHAVIOR PROBLEMS				
Tantrums	**1**	**2**	**3**	**4**
Lies	**1**	**2**	**3**	**4**
Steals	**1**	**2**	**3**	**4**
Breaks things	**1**	**2**	**3**	**4**
Runs away from home	**1**	**2**	**3**	**4**
Sets fires	**1**	**2**	**3**	**4**
	NOT A PROBLEM	**SOMEWHAT A PROBLEM**	**A PROBLEM**	**A SEVERE PROBLEM**
Hurts animals	**1**	**2**	**3**	**4**
Assaultive	**1**	**2**	**3**	**4**
Uses alcohol	**1**	**2**	**3**	**4**
Uses drugs	**1**	**2**	**3**	**4**
Other:	**1**	**2**	**3**	**4**
COMMUNICATION SKILLS				
Limited Speech	**1**	**2**	**3**	**4**
Repetitive Speech	**1**	**2**	**3**	**4**
Regression in Speech	**1**	**2**	**3**	**4**
SOCIAL SKILLS				
Makes poor eye contact	**1**	**2**	**3**	**4**
Afraid of many things	**1**	**2**	**3**	**4**
Very Shy	**1**	**2**	**3**	**4**
Poor Loser	**1**	**2**	**3**	**4**
Demands too much attention	**1**	**2**	**3**	**4**
Plays Alone				
Withdraws from people	**1**	**2**	**3**	**4**
EMOTIONAL PROBLEMS				
Has unreasonable fears				
Is sad or unhappy most times	**1**	**2**	**3**	**4**
Cries a lot	**1**	**2**	**3**	**4**
Sluggish or Slow	**1**	**2**	**3**	**4**
Tired most of the time	**1**	**2**	**3**	**4**
Mood changes quickly	**1**	**2**	**3**	**4**
Has lost interest in things	**1**	**2**	**3**	**4**
Worries a great deal	**1**	**2**	**3**	**4**
Has difficulty making decisions	**1**	**2**	**3**	**4**
ATTENTION AND SELF-CONTROL				
Has difficulty concentrating	**1**	**2**	**3**	**4**
Is easily distracted	**1**	**2**	**3**	**4**
Can't sit still	**1**	**2**	**3**	**4**
Hyperactive	**1**	**2**	**3**	**4**
Acts without thinking	**1**	**2**	**3**	**4**
Acts impulsively	**1**	**2**	**3**	**4**
Is forgetful	**1**	**2**	**3**	**4**
Is disorganized	**1**	**2**	**3**	**4**
OTHER				
Has threatened or attempted to harm self	**1**	**2**	**3**	**4**
Acts younger than real age	**1**	**2**	**3**	**4**
Wants things to be perfect	**1**	**2**	**3**	**4**
Says or does strange things	**1**	**2**	**3**	**4**
Displays repetitive/odd behaviors	**1**	**2**	**3**	**4**

Hurts Self (how_____)	**1**	**2**	**3**	**4**
Daydreams a lot	**1**	**2**	**3**	**4**
Doesn't finish things	**1**	**2**	**3**	**4**
Bites nails	**1**	**2**	**3**	**4**
Not fully bladder trained	**1**	**2**	**3**	**4**
Not fully bowel trained	**1**	**2**	**3**	**4**
Has aches and pains	**1**	**2**	**3**	**4**
Clumsy and accident prone	**1**	**2**	**3**	**4**
	NOT A PROBLEM	**SOMEWHAT A PROBLEM**	**A PROBLEM**	**A SEVERE PROBLEM**
Fakes being sick	**1**	**2**	**3**	**4**
Chronically Ill	**1**	**2**	**3**	**4**

Please describe other problems: _____

_____

_____

_____

_____

_____

Please describe the positive outcome you would hope to gain from services at this time.

_____

_____

_____

_____

_____

_____

_____

_____

Completed by: _____

Signature: _____ Date: _____