Hallowell Center,P.C
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978-287-0810

DEVELOPMENTAL AND HEALTH HISTORY INFORMATION

Name of Patient: _____ D.O.B: _____/_____/_____ Age: _____

Parent(s) Name: _____ Age: _____ Highest Education _____

Parents(s) Name: _____ Age: _____ Highest Education _____

Legal Guardian: _____

Person Completing Form: _____

FAMILY HISTORY

Family history can often be helpful in understanding a child's problems.
PLEASE CHECK ANY BOX THAT APPLIES

Has anyone in the family had	**Siblings**	**Parents**	**Extended Family**
Motor problems?			
Reading problems			
Speech/language problems?			
School/learning problems?			
Alcohol/drug problems?			
Anxiety, depression, other psychological disorders?			
Seizures/epilepsy?			
Attention problems/hyperactivity?			

Please list all family members (in or out of the house) and other people currently in the house:

NAME	***RELATIONSHIP***	***AGE***	***CURRENTLY IN HOUSE?***

Parents are: **Married _____ Living together _____ Divorced _____ Separated _____ Widowed _____**

BIRTH HISTORY:

Was the pregnancy normal? YES NO

Was the labor and delivery normal? YES NO

(If no to either of the above please describe)_____

Birth Weight: _____ Full Term? YES NO

(If premature, how many weeks early _____)

During pregnancy with this child, did the mother:

Drink alcohol? YES NO Take any drugs? YES NO

Smoke cigarettes? YES NO Take any medications? YES NO

During hospital stay, did baby have any problems? YES NO

(If yes, please describe _____)

Were there any problems in the first year of life? YES NO

(If yes, please describe _____)

DEVELOPMENTAL HISTORY:

How old was the child when (she or he):

	Approximate Age	(If not sure, please estimate)
Sat?	_____	Early Average Late
Walked?	_____	Early Average Late
Toilet trained?	_____	Early Average Late
Said first words?	_____	Early Average Late

During the first twelve months, was this child:

	YES	NO		YES	NO
Difficult to get to sleep?			Irritable?		
Difficult to put on a schedule			Alert?		
Easy to comfort?			Affectionate?		
Overactive/in constant motion?			Sociable?		

SPEECH AND LAGUAGE

Has his/her hearing ever been tested? YES NO

Last hearing/audiology evaluation: PLACE: _____ DATE: _____

RESULTS: _____

Does this child have a history of frequent ear infections? YES NO

Has (she or he) ever had tubes placed in her/his ears? YES NO

Does this child have: YES NO

Any speech problems/difficulty speaking? YES NO

Have trouble understanding what is being said to him/her? YES NO

Has (she or he) HAD A Speech and Language Evaluation? YES NO

If yes, where _____ When _____)

RESULTS _____

Has (she or he) ever had Speech/Language Therapy? YES NO

Is (she or he) currently receiving Speech/Language Therapy? YES NO

(If yes, where _____ Frequency _____)

MOTOR SKILLS

Does this child have fine motor problems (writing, drawing)? YES NO

Has (she or he) had Occupational Therapy (OY) evaluation? YES NO

Is (she or he) currently receiving OT Services YES NO

(If yes, where _____ Frequency _____)

Does (she or he) have any gross motor problems (walking, running)? YES NO

Has (she or he) ever had a Physical Therapy (PT) evaluation? YES NO

Is (she or he) currently receiving PT services? YES NO

If yes, where _____ Frequency _____)

Does this child use any adaptive devices (braces)? YES NO

(If yes, please describe: _____)

VISION

Has this child ever been to an eye doctor? YES NO

Most Recent Date: _____

Does this child wear glasses YES NO

If yes, why: _____)

MEDICAL HISTORY & CURRENT MEDICAL

Is this child generally in good health? YES NO

If no, please describe: _____)

Does this child have allergies? YES NO

(If yes, to what: _____)

Is (she or he) currently taking any medications? YES NO

(If yes, name of medications? _____ Reason: _____

_____ Reason: _____

_____ Reason: _____

Did this child ever have a head injury or concussion? YES NO

Has (she or he) ever had a high level or lead poisoning? YES NO

Does (she or he) have a seizure disorder? YES NO

Has this child ever had any serious illness or hospitalizations? YES NO

(If yes, please describe: _____)

Does this child see any medical specialists (neurologists)? YES NO

(If yes, who: _____ Reason: _____

_____ Reason: _____

SCHOOL HISTORY

Name of school/day care: _____ Grade: _____

Address of School: _____

Has (she or he) ever repeated a grade? YES NO

(If yes, which grade(s) _____

Is there an Ed Plan (IEP)? YES NO

Has (she or he) ever received special/extra help in school? YES NO

Is (she or he) currently receiving special/extra help in school YES NO

If she, please circle types of services being received:

Occupational Therapy Resource Room Speech/Language Reading

Physical Therapy In-Class LD Adaptive Physical Ed. Counseling

Other (specify) _____

Has (she or he) ever had a developmental, psychological, or educational evaluation? YES NO

(including school CORE evaluations.)

If yes, where was the most recent? _____ Date: _____

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have about this child? Also, please add any additional information that you feel is important and may he helpful in our assessment.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Circle the one which best describes the child:

1. Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities

Never Sometimes Often Always

2. Often has difficulty sustaining attention in tasks or play activities

Never Sometimes Often Always

3. Often does not see, to listed when spoken to directly

Never Sometimes Often Always

4. Often does not follow through on instructions and fails to finish schoolwork, or chores (not due to oppositional behavior failure to understand directions)

Never Sometimes Often Always

5. Often has difficulty organizing tasks and activities

Never Sometimes Often Always

6. Often avoids dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

Never Sometimes Often Always

7. Often loses things necessary for tasks or activities (toys, school assignments, pencils or books)

Never Sometimes Often Always

8. Is often easily distracted by extraneous stimuli

Never Sometimes Often Always

9. Is often forgetful in daily activities

Never Sometimes Often Always

10. Often fidgets with hands or feet or squirms in seat

Never Sometimes Often Always

11. Often leaves seat in classroom or in other situation in which remaining seated is expected

Never Sometimes Often Always

12. Often runs about or climbs excessively in situation where it is inappropriate (in adolescents, may be limited to subjective feelings of restlessness)

Never Sometimes Often Always

13. Often has difficulty playing or engaging in leisure activities quietly

Never Sometimes Often Always

14. Is often “on the go” or often acts as if “driven by a motor”

Never Sometimes Often Always

15. Often talks excessively

Never Sometimes Often Always

16. Often blurts out answers before questions have been completed

Never Sometimes Often Always

17. Often has difficulty waiting turn

Never Sometimes Often Always

18. Often interrupts or intrudes on others (butts into conversations or games)

Never Sometimes Often Always