

Center for Testing of Fort Worth Child Developmental History Record

A. Identification

1. Child's name _____ Birthdate _____ Age _____ Grade _____
Person(s) completing this form _____ Today's date _____
Relation to child _____

Please describe your current concerns about your child:

How long have you had these concerns?

2. Please list the names, relations, and age of people who currently live with the child.

Name _____	Relation to child _____	Age _____
Name _____	Relation to child _____	Age _____
Name _____	Relation to child _____	Age _____
Name _____	Relation to child _____	Age _____
Name _____	Relation to child _____	Age _____

3. Mother's name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____ Email _____
Currently employed: **NO YES** as _____ Cell phone _____

4. Father's name _____ Birthdate _____ Home phone _____
Address _____ City _____ State _____ Zip _____ Email _____
Currently employed: **NO YES** as _____ Cell phone _____
Party responsible for bill _____ Birth Date _____

5. Parents are currently **Married Divorced Remarried Never married** Other _____
If you are divorced/separated, how old was your child when you separated? _____ Date of Divorce _____
If divorced, what is the custody arrangement? _____
Child's legal custodian/guardian is _____

B. Family Changes and Loss History

Have any of the following changes occurred in your child's life? (Please give dates)

- Separation Divorce of parents Parent's remarriage/new partner Parent incarcerated
 Death of a family member Job loss/New job of parent Death of a pet
 Birth/Adoption of a sibling Serious illness (child) Move to a new home
 Addiction of a family member Serious illness (family member) Separation from parent
 Traumatic experience Accident Other _____

Describe: _____

C. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery

Any prenatal (before birth) problems? _____

Was the child premature? _____ Weight and height at birth _____

Any birth complications or problems?

2. The first few months of life

Breast-fed? _____ If so, for how long? _____

Any allergies? _____

Please list any problems during infancy

3. Has there been a delay in any of the following developmental milestones?

Sit with support _____ Crawl _____

Walk without holding on _____ Help when being dressed _____

Eat with a fork _____ Stay dry all day _____

Didn't soil his/her pants _____ Stay dry all night _____

Dress self completely _____

4. Speech/language development

Age when child said first word understandable to strangers _____

Age when child said first sentence understandable to strangers _____

Any speech, hearing or language difficulties? _____

D. Health

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all **current** medications the child is taking.

Name of medication	Time child took last dosage	Dosage prescribed	How many times per day
_____	_____	_____	_____
_____	_____	_____	_____

Please list **past** medications child has taken previously

E. Behavior

Please list any concerns you have about your child's behavior.

How does your child get along with peers?

How does your child get along with siblings?

To your knowledge, has your child ever been abused or neglected?

Is there anyone in the child's family that has ever had:

Family member(s)

Learning Difficulties _____

Attentional Problems _____

Emotional Difficulties _____

Diagnosed Disorder(s) _____

Alcohol or Drug problems _____

Their own history of abuse _____

Please list any **current** intervention your child is receiving (Speech, OT, PT, psychotherapy)

From	To	Description of treatment/Providers name	Diagnosis
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Please list any **past** treatment for your child (Speech, OT, PT, psychotherapy)

From	To	Description of treatment/Providers name	Diagnosis
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Please list any **past** evaluations for your child (Speech, OT, PT, Psychological), and the provider's name

F. Schools/Learning

Please list current school child your attends

Grade

Concerns

Does your child currently receive any special education services? _____

If so, what is your child's classification _____

How often does your child receive services? _____

Has your child ever received any special services in the past? _____

Behavior questions:

Please list your child's play interests, toy preferences, and any special talents.

What things do you and your child enjoy doing together?

What methods do you use for discipline?

Please list any other information that you think is important with regard to your child.
