MEEKER & WRIGHT SPECIAL EDUCATION COOPERATIVE
EARLY INTERVENTION
DEVELOPMENTAL HISTORY

The purpose of this form is to gather information on your observations about your child and issues that may affect your child's development. Your ideas and information are an important part of the evaluation process and will be included in the Evaluation Summary Report. Answer as many items as you feel comfortable sharing.

Parent Information

Today's Date:____/____/____

Child's Full Name:_____
(First, Middle, Last)

Birthdate:____/____/____ ☐ Male ☐ Female

Address: _____
Street City State Zip

Phone(s) Home:_____ Work: _____ Cell: _____

Email address:_____

Mother's Name: _____ Age: _____

Address if different from above:_____ Occupation:_____ Education Level:___

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Father's Name: _____ Age: _____

Address if different from above:_____ Occupation:_____ Education Level: ____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Child's Ethnicity/ Race:

❑ Hispanic /Latino ❑ American Indian or Alaska Native ❑ Asian ❑ White / Caucasian ❑ Black / African American ❑ Native Hawaiian or Other Pacific Islander

Child's Primary Language spoken in the home:_____

Does your child attend daycare? Yes ❑ No ❑ If yes, when?_____

Name of Provider:_____ Phone: _____

Address: _____
Street City State Zip

Child's Primary Physician or Pediatrician:

Doctor's Name: _____ Clinic/Hospital Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

Early Childhood Screening:

If over age 3, has your child participated in early childhood screening? Y / N

If yes, did your child pass the following?

Vision__Y/N Hearing__Y/N Developmental screening__Y/N Speech/language screening__Y/N

Medical Information

Has your child been evaluated by or received services from any of the following (check all that apply):

❑ Physician ❑ Dental ❑ School ❑ Hearing ❑ Vision

❑ Speech & Language ❑ Orthopedic ❑ Neurological ❑ Psychological ❑ University or Hospital/Clinic

Please list the provider of the services (if needed use separate page to list all,).

1. Name: _____ Type of Service: _____

Address: _____

Phone: _____ Fax: _____ Date of Service: _____

2. Name: _____ Type of Service: _____

Address: _____

Phone: _____ Fax: _____ Date of Service: _____

Has your child had any of the following illnesses or conditions?

Illness/Condition	Yes	No	Age	Treatment / Comments
Colic				
Chronic Lung Conditions				
Kidney Problems				
Seizure Problems				
Cytomegalovirus (CMV)				
Meningitis/encephalitis (circle)				
Severe Reaction to Immunizations				
Scarlet Fever/Strep Infection (circle)				
Frequent Colds				
Ear Infect./Middle Ear Fluid (circle)				
Sinus Infections				
Tonsillitis/Bronchitis (circle)				
Pneumonia/RSV (circle)				
High Fevers				
Allergies (include foods)				
Growth Concerns				
Exposure to Tuberculosis or Hepatitis				
Head Injury (concussion/skull fracture)				
Loss of Consciousness				
Serious Accident/Poisoning (circle)				
Other				

Is your child currently on a long term medication? ❑ Yes ❑ No Type: _____

Has your child been hospitalized since birth? ❑ Yes ❑ No How many times? _____

Hospital Name Reason Age Length of Stay Dr.'s Name

_____

_____

_____

Immunizations: Are all your child's immunizations up to date? ❑ Yes ❑ No

PRENATAL HISTORY:

Pregnancy Condition	Yes	No	Months	Treatment
Nutritional Problems/Vomiting/Anemia (circle)				
Bleeding/Spotting				
Toxemia/High Blood Pressure/PreEclampsia (circle)				
Accident/Injuries (circle)				
Pre-Term Labor				
Cigarettes/Alcohol/Drug Use (circle)				
Medications				
Ultrasound/X-rays (circle)				
Amniocentesis/Chorionic Villus Sampling (CVS) (circle)				
Rash, Measles, Mumps, Chicken Pox (circle)				
Diabetes				
Cytomegalovirus (CVM)				
Rh Incompatibility				
Seizures				
Depression/Emotional Stress				
Illness/Infection				

Mother's Age at Delivery: _____ Month of pregnancy that prenatal care began:_____

BIRTH HISTORY:

Was your child adopted? Yes ❑ No ❑ If yes, at what age: _____

Length of pregnancy (# of weeks):_____ Duration of labor:_____

Birth Weight. _____ Birth Length. _____ Head Circumference_____

How was your child delivered?:

❑ Head First ❑ Breech (butt first) ❑ Footling (feet first) ❑ Caesarean

Yes ❑ No ❑ Was this a multiple birth?

Yes ❑ No ❑ Was oxygen required for baby?

Yes ❑ No ❑ Was the umbilical cord wrapped around the baby's neck?

Yes ❑ No ❑ Did baby have difficulty with sucking or crying when first brought to mother?

Yes ❑ No ❑ Was labor induced? If yes, why? _____

Yes ❑ No ❑ Did baby go to an NICU? If yes, where? _____

Yes ❑ No ❑ Was baby on an apnea and/or heart rate monitor?

Did baby breathe on own? ❑ Immediately ❑ Delayed If delayed, how long?_____

NEONATAL HISTORY:

Did any of the following occur within the first 28 days of life? Please check all that apply.

❑ Anemia ❑ Failure to thrive ❑ Chemical (withdrawal symptoms)

❑ CMV ❑ Jaundice ❑ Cyanosis (turning blue)

❑ HIV/AIDS ❑ Respiratory Difficulties ❑ Seizures/Convulsions

❑ Excessive Wt. Loss ❑ Skin Problems (rashes) ❑ Transfusions

❑ Fever ❑ Elimination Problems (diarrhea/constipation)

❑ Infections (Types):_____

❑ Physical Anomalies (Describe):_____

❑ Other? (Describe): _____

Vision

Does your child exhibit any of the following:

- ❑ Redness / Watering
- ❑ Rubbing
- ❑ Squinting
- ❑ Excessive staring
- ❑ Eyes turn inward or out
- ❑ Avoids eye contact
- ❑ Hold objects close to eyes
- ❑ Closes one eye when looking at objects
- ❑ Show an unusual interest in mirrors/lights

Has your child ever had his/her vision tested?	❑ Yes	❑ No	Date _____
Have glasses been prescribed for your child?	❑ Yes	❑ No	
If yes, are they worn as prescribed?	❑ Yes	❑ No	
Are you concerned about your child's vision?	❑Yes	❑ No	

If yes, please describe: _____

Hearing

Please check all that apply:

- ❑ Infection during pregnancy, or child had an infection when he/she was born (such as CMV, syphilis, German measles)
- ❑ Changes in his/her head or face (such as no ear canal, cleft palate, etc.)
- ❑ Your child has a medical syndrome (such as Down Syndrome).
- ❑ Your child was given antibiotics known to cause hearing problems (example: Gentamicin, Vancomycin, etc.)
- ❑ Your child had mumps or measles.
- ❑ Your child has a progressive nervous system disease (such as neurofibromatosis, demyelinating disorder, etc.)
- ❑ Your child did not pass his/her newborn hearing screening.

Does your child:

Startle at loud sounds?	❑ Yes	❑ No
Often need directions repeated in a louder voice?	❑ Yes	❑ No
Appear to be "deaf", daydreaming or ignoring some sounds?	❑ Yes	❑ No
Seem to hear better on some days than on others?	❑ Yes	❑ No
Have difficulty hearing when he/she has a cold/earache?	❑ Yes	❑ No
Turn to find source of sound?	❑ Yes	❑ No
Watch your mouth or face intently when spoken to?	❑ Yes	❑ No
Respond consistently to voices or sounds?	❑ Yes	❑ No
Have tubes in his/her ears?	❑ Yes	❑ No
Have hearing aid(s) ever been prescribed?	❑Yes	❑ No
Has your child had his/her ears checked by an audiologist?	❑ Yes	❑ No

Feeding Skills

Current Height / Length: _____ Current Weight: _____

Eating Skills:

At what age did your child begin eating baby foods? _____ Table foods? _____

Where there any difficulties making the transition between these foods? ❑ Yes ❑ No

If yes, please describe: _____

Does your child use his/her fingers, a spoon, or a fork to eat? Please describe _____

_____

Does your child drink out of a bottle, sippy cup, or cup? Please describe _____

_____

Does your child drool more than other children his/her age? _____

Has your child ever had difficulty gaining weight? _____

_____

Does your child have any particular food preferences or dislikes? Please describe: _____

_____

Is your child a picky eater? Please describe: _____

_____

Does your child have food allergies? Please describe: _____

_____

Does your child have any unusual cravings for things to eat or chew on?

Please describe: _____

_____

_____

_____

Does your child have certain eating habits such as refusing to drink from a transparent container, eating only hot (or cold) food, eating only one or two foods, etc.? Please describe: _____

_____

_____

Has your child had any feeding difficulties? Please check each item that applies:

- ❑ Difficulty sucking or nursing
- ❑ Difficulty keeping tongue inside mouth
- ❑ Takes an excessive amount of time to eat or drink
- ❑ Regurgitates liquids or solids through the nose
- ❑ Difficulty chewing or swallowing meats
- ❑ Choking and/or gagging on certain foods

Describe any feeding challenges your child has experienced: _____

_____

Speech & Language Development

Please indicate at what age your child began the following:

Coo/Babble _____ Imitate sounds _____ Imitate words _____

Say any single words _____ Imitate Actions (i.e. clapping, give me 5, etc.) _____

Put 2-3 words together _____ Speak in sentences _____

Please give examples of some of your child's sounds, words, or phrases:_____

_____

How does your child let you know his/her wants and needs? _____

_____

Describe any concerns you have about your child's speech and language_____

_____

When did you first become concerned? _____

Does your child become frustrated when he/she is unable to communicate? ❑ Yes ❑ No

If yes, please describe: _____

What efforts does your child make when not understood by others? _____

_____

How much of your child's speech can you understand?

❑ None ❑ 25% ❑ 50% ❑ 75% ❑ 100%

How much of your child's speech can persons other than your immediate family understand?

❑ None ❑ 25% ❑ 50% ❑ 75% ❑ 100%

Has your child's speech development ever seemed to stop or regress for a time? ☐ Yes ☐ No

If yes, please describe: _____

_____

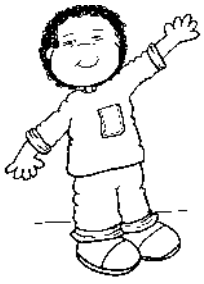
Does your child use his/her index finger to point, to ask for something? ❑ Yes ❑ No

Dees your child use his/her index finger to point, to indicate interest in something? ❑ Yes ❑ No

Does your child bring objects over to you (parent) to show you something? ❑ Yes ❑ No

Does your child take an adult by the wrist to use adult's hand to open a door, get cookies, turn on the TV, ect.? ❑ Yes ❑ No

Does your child (check all that apply):



❑ Responds to voices

❑ Responds to his/her name

❑ Points to objects / pictures when named

❑ Understands most of what is said to him/her

❑ Looks up at people (meets their eyes) when they are talking to him/her

❑ Repeats phrases or sentences heard in the past that have little or no relationship to the current situation

What directions does your child follow? Please give examples:_____

Motor Skills

MOTOR DEVELOPMENT:

At what age did your child do the following:

Hold his/her head up _____ Reach with arms to be picked up _____

Reach and grasp a toy _____ Roll over _____

Sit alone _____ Pull to stand by self _____

Crawl on hands and knees _____ Walk unassisted _____

Undress self _____

GROSS MOTOR: (large muscle)

Is your child able to independently walk up and down stairs? **Yes / No**

Does your child place one foot on each step/ two feet per step / hold the rail? (circle what applies)

Is your child able to catch a ball gently tossed? **Yes / No**

Is your child able to throw a ball with good aim towards a person? **Yes / No**

Does your child move a small riding toy using feet? **Yes / No**

Does your child independently pedal a trike? **Yes / No**

Does your child's muscle tone seem unusually rigid (stiff) or floppy? **Yes / No**

If yes, please describe:_____

Do you have any concerns about your child's ability to move around? **Yes / No**

If yes, please describe:_____

FINE MOTOR: (small muscle)

As an infant or toddler, does your child…….

Keep hands primarily open? **Yes / No**

Use both hands together? **Yes / No**

Move objects from one hand to the other? **Yes / No**

Use the thumb and pointer finger to pick up small items / food pieces? **Yes / No**

Scribble with a crayon or marker? **Yes / No**

Use one hand to hold and the other to play with a toy? **Yes / No**

Snip paper with scissors? **Yes / No**

Imitate vertical and circular scribbles? **Yes / No**

Stack at least 3 blocks on top of each other? **Yes / No**

Hold a crayon with fingers and not the fist? **Yes / No**

As a preschooler, does your child……

Use one hand to hold a paper and the other to color or cut? **Yes / No**

Cut on straight and curved lines on paper? **Yes / No**

Reach across the middle of the body from one side to the other without twisting the trunk? **Yes / No**

Show a dominant hand preference? **Yes / No**

Write the letters in their first name? **Yes / No**

Hold a pencil or crayon like an adult? **Yes / No**

Have you noticed any unusual trembling while your child is using his hands to play or eat? **Yes / No**
If yes, please describe: _____

Social/Emotional Development

Social History:
Check all of the following which best describe your child:

- ❑ Quiet ❑ Cooperative ❑ Calm ❑ Happy
- ❑ Sensitive ❑ Aggressive ❑ Shy ❑ Uncooperative
- ❑ Moody ❑ Active ❑ Talkative ❑ Creative
- ❑ Withdrawn ❑ Fussy ❑ Independent ❑ Easily angered
- ❑ Other _____

How does your child respond to your attention? Please check all that apply:

- ❑ Cuddles ❑ Reserved ❑ Doesn't respond ❑ Avoids/runs away
- ❑ Shows affection ❑ Withdraws ❑ Clings excessively
- ❑ Other, Please describe: _____

Check all of the following which your child exhibits:

- ❑ Short attention span ❑ Seeks attention ❑ Starts fights ❑ Nail biting
- ❑ Thumb sucking ❑ Won't leave mother ❑ Stutters ❑ Teases
- ❑ Nightmares ❑ Sleep difficulties ❑ Temper tantrums ❑ Destructiveness
- ❑ Other, Please describe: _____

_____

Does your child have any unusual fears or behaviors? If yes, please describe: _____

_____

_____

Does your child have a "fussy" time? ❑ No ❑ Yes If yes, when? _____

_____

How do you handle it? _____

_____

What makes your child angry or upset? _____

_____

How does your child usually react to being interrupted at what he/she is doing?

❑ Rarely or never gets upset ❑ Sometimes gets mildly upset, rarely very upset ❑ Typically gets very upset

For children ages 3-5:

Does your child hit, pinch, bite or otherwise injure himself/herself or others more than usual? _____

- ❑ Yes, self only ❑ Yes, others only
- ❑ Yes, self and others ❑ No (not a problem)

Describe the methods of discipline you use with your child. What works best? What's the most difficult? _____

_____

Play Skills

Which of the following describes the type of play your child likes to engage in most often?

- ❑ Putting toys in mouth
- ❑ Throwing toys
- ❑ Pushing/pulling toys
- ❑ Banging toys together
- ❑ Peek-a-boo/Hide-and-seek
- ❑ Shaking toys
- ❑ Rough and tumble play
- ❑ Looking at books
- ❑ Uses one object for another
- ❑ Appropriate use of objects
- ❑ Acting out familiar routines
- ❑ Role-playing / pretend play
- ❑ Games with rules

Which activities seem to hold your child's attention for the longest period of time?

_____

_____

Is your child's play easily distracted by any of the following?

- ❑ Nearby activities
- ❑ Other people in the room
- ❑ Visual stimuli (i.e., other toys or objects)
- ❑ Auditory stimuli (i.e., voices, sounds outside, the TV)

Does your child take an interest in other children? ❑ No ❑ Yes

How much opportunity does your child have to play with other children the same age? _____

_____

How does your child get along with his/her siblings? _____

_____

Self Help Skills

How does your child participate in dressing / undressing?_____

Describe your child's toileting skills: _____

Describe ways your child may be helpful around the house: _____

Give a general description of your child's day: _____

_____

Does your child sleep through the night? _____

Does your child sleep in his/her own bed? _____

Generally, what time does your child:

wake up _____ nap_____ go to bed_____

Sensory System

VESTIBULAR: (body movement through space)
Does/did your child:

Fall or trip often	❑ Yes	❑ No
Lose balance easily	❑ Yes	❑ No
Like to rock, swing or spin excessively	❑ Yes	❑ No
Have head-neck-shoulder rigidity	❑ Yes	❑ No
Resist movement activities	❑ Yes	❑ No
Bump into objects	❑ Yes	❑ No
Use one hand for two-handed activities	❑ Yes	❑ No

Other: _____

Comments: _____

PROPRIOCEPTIVE: (awareness of body position)
Does/did your child:

Flap hands, stamp, clap, jump to unusual degree	❑ Yes	❑ No
Toe-walk	❑ Yes	❑ No
Climb in inappropriate places	❑ Yes	❑ No
Bang head	❑ Yes	❑ No
Grind/clench teeth	❑ Yes	❑ No
Exhibit clumsy/awkward movements	❑ Yes	❑ No
Have difficulty positioning self on furniture	❑ Yes	❑ No
Become physically rough with others/objects	❑ Yes	❑ No

Other: _____

Comments: _____

TACTILE/TOUCH:
Does/did your child:

Become irritated or avoid certain clothing	❑ Yes	❑ No
Show sensitivity to certain textures/temperatures	❑ Yes	❑ No
Over/under react to mild pain	❑ Yes	❑ No
Resist bathing, brushing teeth, haircuts	❑ Yes	❑ No
Exhibit clingy behavior	❑ Yes	❑ No
Show discomfort when approached/touched	❑ Yes	❑ No
Insist on large personal space	❑ Yes	❑ No

Other: _____

Comments: _____

This Developmental History was compiled from a variety of sources, most of them informal samples from various districts. No intent was made to directly copy from another, but to take relevant questions and group them accordingly. The sole purpose is to gather accurate

information on young children referred for a special education evaluation. The information will be summarized in the Evaluation Summary Report and remain part of the child's special education record.

12-1-10
Revised by Meeker & Wright Special Education Cooperative in conjunction with Little Crow Special Education Cooperative and their 2002 revisions