K-12 Initial Developmental History Questionnaire

I. GENERAL INFORMATION

Student Information

Student Name:	Date of Birth:	Age:

Contact Information

Person(s) completing this form: Relationship to child

What is your child's primary language?

Please list who currently lives in the home:

Name	Relationship to Child	Age and Education Level	Primary Language

Does cultural heritage play a significant role in your daily life? ☐ Yes ☐ No

Has your child experienced any parental separations or the death of any family members? ☐ Yes ☐ No

If yes, please describe the circumstances (e.g., your child's age and the event):

Is either parent away from home for several days at a time on a regular basis? ☐ Yes ☐ No

If parents are divorced or separated, how often does your child visit with the other parent?

Does your child have a history of:

Physical abuse ☐ Yes ☐ No ☐ I Don't Know

Sexual abuse ☐ Yes ☐ No ☐ I Don't Know

Emotional abuse ☐ Yes ☐ No ☐ I Don't Know

Is your child adopted: ☐ Yes ☐ No If yes, how old was your child at the time of adoption?

Is your child aware of the adoption? ☐ Yes ☐ No

Is your child receiving any special services at school or outside of school? *(please check)*

☐ Speech/language therapy ☐ Counselor/therapist ☐ Psychologist ☐ PCA care

☐ Occupational/Physical therapy ☐ Tutoring ☐ Psychiatrist ☐ ARC

☐ Respite care ☐ County social worker ☐ Developmental disorder social worker

☐ PACER ☐ Foster care ☐ Other:_____

Has anyone in your family experienced difficulties with learning, behavioral or mental health issues?
If yes, please describe:

II. MEDICAL AND DEVELOPMENTAL HISTORY

Describe any complications, medications, or other concerns the mother experienced before or during the pregnancy: *(e.g., diabetes, high blood pressure, toxemia, etc.)*

What was duration of pregnancy:	Cesarean Section? ☐ Yes ☐ No	Birth Weight

Please describe any complications the child experienced with the birth, delivery, or after delivery: *(e.g., low Apgar scores, cord around neck, breathing difficulties, time in NICU, etc.)*

List any serious illness, injury, hospitalization, or surgery: *(e.g., diabetes, seizures, head injury, asthma, allergies, etc.)*	Child's age at the time:

Developmental Information

	Age		Age		Age		Age
Sat alone	_____	Walked alone	_____	Put several words together	_____	Toilet trained	_____
Crawled	_____	Spoke first word	_____	Spoke in complete sentences	_____	Stayed dry at night	_____

Do you have any concerns about your child's development? ☐ Yes ☐ No

If yes, please explain:

Are there conditions at home that may be influencing your child's development and/or behavior? ☐ Yes ☐ No *(e.g., family, illness, marital issues, etc.)*

If yes, please explain:

Please describe your child's temperament at the following ages:	Pleasant/happy	Fussy	Colicky	Other
Infancy (birth-12 months):	☐	☐	☐	_____
Toddler (12-36 months):	☐	☐	☐	_____
Preschool (36-60 months):	☐	☐	☐	_____

Has your child shown any loss of previous abilities *(e.g., speaking in two word sentences, and then stopped talking)*. ☐ Yes ☐ No

If yes, please describe:

As an infant, did your child like to be held? ☐ Yes ☐ No

As a young child, did he/she coo and babble? ☐ Yes ☐ No

As a young child, did he/she respond to his/her name being called? ☐ Yes ☐ No

As a young child, did he/she imitate sounds/words? ☐ Yes ☐ No

Does your child have problems with:

Large motor coordination (i.e., running, jumping, etc.) ☐ Yes ☐ No

Small motor coordination (i.e., handwriting, cutting, etc.) ☐ Yes ☐ No

If yes, please describe:

Does your child experience any of the following difficulties with sleep? *(please check)* ☐ Yes ☐ No

☐ Difficulty falling asleep ☐ Snoring ☐ Sleeps too much ☐ Falls asleep during the day *(other than age appropriate naps):*

☐ Night Terrors ☐ Walking in the night ☐ Sleep Apnea

☐ Nightmares ☐ Early morning waking ☐ Other:_____

What is a typical sleep schedule for your child?

Does your child have any of the following difficulties with eating? *(please check)*

☐ Difficulty sitting at table ☐ Overeats ☐ Avoids food due to texture ☐ Other:_____

☐ Poor food choices ☐ Picky Eater ☐ Odd eating behaviors/habits

Does your child have difficulties with bowel or bladder control? ☐ Yes ☐ No

If yes, please explain:

Does your child frequently complain of physical symptoms not related to medical problems? *(please check)*

☐ Stomach aches ☐ Fatigue ☐ Heart Palpitations

☐ Headaches ☐ Dizziness ☐ Breathing Problems ☐ Other:_____

☐ Joint aches ☐ Tremors/Shakes

III. SELF-CARE AND PERSONAL SAFETY

Does your child understand basic safety rules and concepts for his/her age? ☐ Yes ☐ No

Does your child need more supervision than other children in order to remain safe? ☐ Yes ☐ No

Does your child need the same amount of supervision as other children in order to remain safe? ☐ Yes ☐ No

Rate your child's ability to complete the following daily tasks independently:

	Never	Sometimes	Always
Dressing	☐	☐	☐
Bathing	☐	☐	☐
Taking care of belongings	☐	☐	☐
Playing with friends	☐	☐	☐

Does your child have difficulty learning new skills? ☐ Yes ☐ No

Does your child demonstrate any unusual or seemingly advanced skills? ☐ Yes ☐ No

If yes, please describe:

IV. SOCIAL INTERACTION

Do you currently have any concerns about your child's social skills?	☐ Yes ☐ No
If yes, what are your concerns?	
Does your child have difficulty making and keeping friends?	☐ Yes ☐ No
Does your child tend to play alongside rather than with other children?	☐ Yes ☐ No
Does your child interact during play? (i.e., talk, share, cooperate, etc.)	☐ Yes ☐ No
Does your child seem to want others to share in their enjoyment of something?	☐ Yes ☐ No
Does your child show an interest in being with other children?	☐ Yes ☐ No
Does your child prefer to play alone?	☐ Yes ☐ No
When around a group of children playing, would your child join in?	☐ Yes ☐ No
Does your child respond on others' emotions and respond appropriately (is he/she able to identify the emotions of others)?	☐ Yes ☐ No
Does your child show a range of facial expressions?	☐ Yes ☐ No
Does your child direct facial expressions towards others to communicate their feelings?	☐ Yes ☐ No
Does your child make eye contact with you and others during social interactions?	☐ Yes ☐ No
Does he/she seem to be able to maintain eye contact?	☐ Yes ☐ No
Does your child ever offer to share things with you, such as food, toys, or favorite objects?	☐ Yes ☐ No
Does your child ever offer to share things with other children?	☐ Yes ☐ No
How does your child respond when asked to play?	
What makes your child excited and happy?	

V. SOCIAL COMMUNICATION

What are your concerns about your child's communication:	
Did your child have an unusual interest in letters or numbers?	☐ Yes ☐ No
If yes, was your child still able to communicate basic wants/needs?	☐ Yes ☐ No
Does your child repeat memorized words/phrases from books, videos or movies?	☐ Yes ☐ No
Does your child have problems with articulation (clarity of speech)?	☐ Yes ☐ No
Does your child speak with volume/pitch that is not appropriate to the situation?	☐ Yes ☐ No
Does your child use a monotone or "sing song" voice when speaking?	☐ Yes ☐ No

Does your child: (*check all that apply)*

☐ greet others	☐ make requests	☐ comment on activities	☐ ask for help
☐ respond to greetings	☐ describe events	☐ share information about himself	☐ look at you when you call their name

How does your child let you know he/she wants something? How does he/she request things or make his needs known?

What gestures does your child use? (*check all that apply)*

☐ Hand out/point ☐ Nod head ☐ Wave hand ☐ Use hand to describe something

Does he/she expand upon their answers to your questions and are they able to hold a back-and-forth conversation with you?

Does your child initiate conversations with you? (i.e. ask questions, make comments)

Is your child able to answer questions that you ask?	Yes/No Questions	☐ Yes	☐ No
	Open-ended Questions	☐ Yes	☐ No
If you give your child one direction at a time:	Can he/she follow the direction	☐ Yes	☐ No
	Can he/she follow a series of directions?	☐ Yes	☐ No

VI. UNUSUAL AND/OR ATYPICAL BEHAVIOR

Are you concerned about your child's behavior?

What are your child's behavioral strengths?

Describe your child's favorite activities.

A. Of these activities listed, what activity holds your child's attention?

B. Which of these activities does your child initiate independently?

Describe your child's activity level *(please check)*

☐ Calm ☐ Busy ☐ Overactive ☐ Underactive

Does your child's attention span impact their ability to complete activities? (i.e. homework, daily living skills, following directions, daily routines) ☐ Yes ☐ No

Does your child have any interests that seem unusual for his/her age or seem unusual in intensity? ☐ Yes ☐ No

If yes, please describe:

Have you noticed differences compared to other children in how your child responds to touch, sound, smells, or light (e.g., licks, smells, sniffs inedible objects, sensitive to clothing, visually inspects objects, sensitive to noises, etc.)?. ☐ Yes ☐ No

If yes, please describe:

Does your child demonstrate any unusual behaviors that seem different from other children (e.g., flapping arms, walking on tip-toes or in circles, rocking, rapid lunging, obsessed with routines, self-injurious behavior)? ☐ Yes ☐ No

If yes, please describe:

Does your child react negatively to changes in daily routine or schedule (e.g., appears anxious, easily upset, shuts down, adjusts if prepared ahead of time, responds negatively or with tantrums when given commands/requests/directions)? ☐ Yes ☐ No

If yes, please describe:

Does your child appear overly concerned with order and routine in his/her daily activities (e.g., lining things up, needing things in a certain order, others following his/her 'rules)? ☐ Yes ☐ No

If yes, please describe:

Does your child tend to get 'stuck' or fixate on things? ☐ Yes ☐ No

If yes, please describe:

How does your child cope when switching activities?

☐ easily ☐ needs assistance ☐ challenging

How does your child cope with moving from one location to the next?

☐ easily ☐ needs assistance ☐ challenging

Does your child have temper tantrums or behavioral outbursts? ☐ Yes ☐ No

If yes, please describe: