

Developmental History Questionnaire

This questionnaire will provide the IEP team with critical and relevant development and health information in making appropriate and individualized education determinations and decisions.

Student Name	Today's Date
Psychologist's Name	
Psychologist's eMail	
Your name	Relationship
Birthday	Age Grade
School	

What are your educational concerns, if applicable, include learning, social-emotional, and developmental:

Who does child live with:	Both	Parents	Mother	Father	Other (specify)
List all family members livin	ng with this	student:			

Name	Age	Relationship	Occupation



List all non-family members living with this student:

Name	Age	Relationship	Occupation

If the student does not live with both biological parents, please describe major events with dates:

How long have you lived in your current residence? List all the cities and states lived in and schools attended by the student:

Date	City	State	Grade	School



List any major changes or traumatic events in the student's life and if they had a negative or positive e⁻ect on the student:

Before the last 12 months:

Please check the conditions below that describe the health of the child and mother during ...

Mother's Pregnacy

- No complications
 - Blackouts
- Physical injury
- Excessive bleeding
- Anemia
- Hypertension
 - Diabetes
- Emotional stress
- Toxemia
- Alcohol and/or drug use
- Use of tobacco
- Other problem (specify)

Child's Delivery

- Normal
 - Induced labor
- C-section
- Breech birth
- Unusually long labor (>12 hours) Jaundice
- Other problem (specify)

Child's Condition at Birth Normal

- Lack of oxygen
- Breathing problem
- Birth injury/defect
- Other problem (specify)



Additional information:

Length of pregnancy:

	Weeks:		Days:
The student's weight at	t birth:		
	Pounds:		Ounces:

Length of stay and level of care in the hospital:

Level I: Well Newbo Nursery	orn	Spe	cial Care ursery		Ne	onatal Ir	rel III: ntensive (NICU)	-Care	Region Intensiv	vel IV: al Neona re-Care I onal NIC	Jnit
Days:		Days:] D	ays:			Days:		
Name			0-3 Months	4-6 Monti		7-12 Months	13-18 Months	19-24 Month		3-4 Years	Other Age



Excellent Good Fair Poor

	Is your child	currently taking	any medication?	Yes	No
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If yes, please list medications and uses:

Has your child had any chronic health problems, significant illnesses, accidents or surgeries?

TES INO	
If yes, please describe:	
Has your child ever had a head injury/concussion/loss of consciousness?	Yes No
If yes, please provide details, including whether medical attention was requ	uired:



Has your child ever been identified as having a disability? 📃 Yes 📃 No
If yes, by whom, what age, & what disability:
Has your child ever received psychological counseling? 🛛 Yes 🔲 No
If yes, by whom (professional/agency), referring reason and when:
Has your child ever participated in therapy services from a private or public entity
(speech, occupational, physical, vision therapy)? Yes No
If yes, by whom (professional/agency), focus of therapy and when:
Has your child ever participated in educational services from a private entity (i.e., private
tutor, Sylvan Learning Center)? Yes No
If yes, by whom (agency), academic area and when:



Has your child ever participated in an early intervention program

(i.e., regional center)? Yes No

If yes, by whom (agency), focus of intervention and when:

How much time does your child spend on homework each night?

Who helps with homework?

Are there any di, culties with homework?

Please indicate whether you were concerned about any of the following for this student as a child or adolescent. Please provide details

(e.g., when the problem began/ended; the severity of the problem; how it was addressed):

Developmental delays (including motor problems, handwriting, speech problems, or abnormal reactions to sensory stimulation)

Behavior problems at home or school (please comment on their capacity for self-control)



Emotional problems at home or school overreactions, mood swings, fears/anxiety, temper)

Academic or learning problems

Social interaction problems (with peers and/or siblings)

Is there a family history of the following problems?

Learning Di, culties (such as reading, math, writing, spelling)

Speech or Language problem

Developmental Disorder (such as autism, ADHD)

Emotional Problems (such as depression, excessive anxiety, mood swings, etc.)

Intellectual Disability

School Failure (such as failing grades, dropout)

Drug or Alcohol Addiction

Biological family member with the history ...

(parent, sister/brother, aunt/uncle, grandparent, 1st cousin)