siskin children's institute
education • outreach • health care • research

center for DEVELOPMENTAL PEDIATRICS
An academic pediatric practice affiliated with the University of Tennessee College of Medicine Chattanooga

Parent Report – Developmental History

CONFIDENTIAL: Please complete all areas and follow instructions to send electronically

Please note: Items marked by an asterisk (*) are used for statistical purposes only.

You must have Adobe to download this form. Please follow directions on website to save and Send this form to us electronically

1. IDENTIFYING INFORMATION

Child's Name: _____ Birth Date: _____

Address: _____ * Sex: _____ * Race: _____

City/State/Zip: _____ County: _____

Parent(s) or Guardian(s): _____

Home Telephone #: _____ Work Phone #: _____

Cell Phone # (Mother): _____ Cell Phone # (Father): _____

Email: (Mother) _____ Email (Father): _____

Who referred you to this Center for this evaluation (name & relationship):

_____

Primary Care Pediatrician: _____

Name of person completing this form: _____ Relationship to above child: _____

Date completed: _____

2. FAMILY-SOCIAL INFORMATION

Father's Name:	Mother's Name:
Birth Date:	Birth Date:
Occupation:	Occupation:
Employer:	Employer:
Highest school grade completed:	Highest school grade completed:
*Gross annual income:	*Gross annual income:

Current marital status of parents: _____ Marriage Date: _____

Date divorced, if applicable: _____ Date of parent death, if applicable: _____

How long has the child lived at the current address: _____

Where else has the child lived: _____

_____

List all persons living in the child's home:

Name	Age	Relationship to child	Health

List any siblings living outside the home:

Name	Age	Relationship to child	Health

3. PARENTAL CONCERNS

A. What do <u>you</u> think are your child's main problems?

_____

_____

_____

B. What have you been told by doctors, teachers, or others about your child's problems?

_____

_____

_____

C. What would you like to result from your child's developmental evaluation?

_____

_____

_____

4. PREGNANCY HISTORY

This child is the _____of _____children born. (Birth order and total number)

Did the mother:	**No**	**Yes**	**What month(s) of pregnancy**	**Complications and/ or medications**
Receive prenatal care?				
Have illnesses or medical problems?				
Have any known exposures to x-rays, toxins, or chemicals?				
Take prescription medications? (*other than vitamins and iron*)				
Smoke? (*indicate how much*)				
Drink alcoholic beverages? (*indicate how much*)				
Use illicit drugs/substances? (*type and amount, if known*)				

5. BIRTH INFORMATION

Length of pregnancy:	Birth weight _____pounds _____ounces OR _____Grams
Age of mother at delivery: Length of labor:	Delivery complications: ☐ None or describe:
Was labor induced? ☐ No ☐ Yes	Did the baby need medical assistance in starting to Breathe? ☐No ☐Yes Was the baby admitted to the NICU? ☐ No ☐ Yes If Yes, for how long?_____ Any mechanical ventilation?_____ Any blood transfusions?_____
Labor complications: ☐ None or describe:	Were there other complications in the baby? ☐ No or describe:
Birth was: ☐ Normal ☐ C-Section ☐ Breech ☐ Twins or more	How long did the baby stay in the hospital after birth? Why?

Did the baby have health problems in the first 12 months after birth? ☐ No or describe:

6. MEDICAL HISTORY

A. Medication History

List all medicines, vitamins, or supplements your child currently takes:

Name	Amount	Reason

MEDICATION ALLERGIES: ☐ None ☐ Yes, allergic to:_____

Describe past or present medicine concerns or complications: _____

_____

B. Hospitalizations /Surgeries

Has your child ever been hospitalized?

☐ No ☐ Yes

Has your child ever had surgery?

☐ No ☐ Yes

Has your child ever had a major injury?

☐ No ☐ Yes

Why?	When?	Where?

C. Immunizations

Child's immunizations are: ☐ Up to date ☐ Incomplete ☐ Unknown status

Complications from immunizations? ☐ No ☐ Yes, explain: _____

D. Review of Systems

Major health concerns_____

_____

_____

_____

Describe any serious illness:

_____

_____

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Has your child ever had any of the following:

System		Age	Details	System		Age	Details
Head	Head injuries			Lungs	Repeated exposure to tobacco smoke		
	Hydrocephalus						
Eyes	☐ vision problem ☐ glasses			Heart	Rapid heartbeat		
	Eye surgery				Heart defects		
	Last vision screen			Endo	Excess ☐ hunger ☐ thirst		
Ears	Hearing problem				Always too ☐ hot ☐ cold		
	Hearing aids				Weight problem		
	Recurrent otitis media				Height problem		
	PE tubes			GI	Stomachache		
	Last hearing screen				GE reflux		
Nose	Recurrent sinusitis				Recurrent diarrhea		
	Nosebleeds				Recurrent constipation		
	Adenoidectomy				Soiling ☐ day ☐ night		
Teeth	Teeth grinding				Eating/mouthing nonfoods		
	Cavities			GU	Circumcision		
	Dental work				Hernia repair		
Throat	Recurrent Strep throat				Wetting ☐ day ☐ night		
	Tonsillectomy			MS	Clumsiness		
Allergy	Seasonal				Weakness		
	Food				Poor handwriting		
	Medication				Broken bones		
	Allergy testing				Birth defects		
Skin	Dermatitis/eczema			Brain	Meningitis		
	Acne				Headache		
	Birthmarks				Dizziness		
	☐ stitches ☐ scars				Staring spells		
Blood/ Lymph	Lead poisoning				Seizures		
	Anemia				Tics: ☐ motor ☐ vocal		
	Bleeding			Psych	☐ depression ☐ mania		
	Big lymph nodes				☐ worry ☐ fear ☐ panic		
Lungs	Asthma				Adjustment problems		
	Pneumonia				Disruptive behavior		
					History of counseling		

☐ All other systems are negative except those noted above

Previous Lab Work / EEGs / CAT Scans / MRI scans / Other:

7. CHILD'S GROWTH AND DEVELOPMENT

Has your child lost any previously acquired skills? ☐ No ☐ Yes (*what, when*) _____

A. Feeding / Nutrition

Baby was ☐ breast-fed ☐ bottle-fed

Special formulas used?

_____

Infant feeding problems? ☐ None or describe:

_____

At what age did your child:
Stop drinking from a bottle: _____

Begin drinking from a cup: _____

Begin feeding him/herself: _____

Does your child take nutritional supplements or vitamins regularly?
☐ No or type _____

For his/her age, height is: ☐ average ☐ short ☐ tall

For his/her age, weight is: ☐ average ☐ overweight ☐ underweight

Does your child currently have problems with:

Self feeding: ☐ with hands ☐ with utensils

☐ chewing ☐ food textures ☐ limited food preferences

☐ poor appetite ☐ sitting for completion of meal

☐ swallowing

Is your child's normal diet well balanced? ☐ No ☐ Yes

What are yourchild's preferred foods?

_____

Describe other eating problems or unusual habits or preferences, if any:

_____

_____

B. Self Care

At what age was your child:

Able to dress alone _____ Able to bathe alone _____ Bladder trained _____
Bowel trained _____ Dry at night _____ Tie shoelaces _____

Concerns about daily living skills: ☐ Bathing ☐ Dressing ☐ Hygiene ☐ Toileting ☐ Other _____

C. Sleep

Did your child have sleep problems as an infant?
☐ No ☐ Yes, explain:

_____

_____

Does your child still take day-time naps?

☐ No ☐ Yes, when and how long?

_____

When is your child's regular bedtime?

In bed _____

Asleep _____

AM Wake up _____

Does your child have a TV in his/her bedroom? ☐ No ☐ Yes

Does your child watch within 1 hr. of bedtime? ☐ No ☐ Yes

Does your child have bedtime routines? ☐ No ☐ Yes, describe:

_____

Does your child currently have sleep problems?

☐ No ☐ Yes

☐ Bedtime refusal ☐ Delayed sleep onset
☐ Mouth breathing ☐ Nightmares or terrors
☐ Nighttime waking ☐ Restless

☐ Sleep talking ☐ Sleep walking
☐ Snoring ☐ Teeth grinding
☐ Will not sleep alone
☐ Other _____

D. Motor Skills

Gross Motor:

At what age did your child:

Smile ____ Roll over ____ Sit alone ____

Crawl ____ Pull to stand ____ Walk alone ____

Learn to climb ____ Pedal a tricycle ____

Does your child have problems with:
☐ Balance ☐ Coordination

Do you have any current concerns about your child's gross motor skills? ☐ No ☐ Yes, explain:

_____

Fine Motor:

Can your child: Button: Snap: Zip:

Does your child: Color easily: Write neatly:

Does your child have problems with: ☐ Using scissors

☐ Grip ☐ Fasteners ☐ Handwriting

Do you have any current concerns about your child's fine motor skills? ☐ No ☐ Yes, explain:

_____

Repetitive Motor Behaviors:

Does your child have any of the following repetitive motor behaviors?

☐ body stiffening ☐ finger/hand posturing
☐ hand flapping ☐ pacing ☐ rocking

☐ spinning ☐ toe walking

Other repetitive movements (describe):

_____

Excessive picking at _____

Does your child pull out and/or eat hair?
☐ No ☐ Yes

Aggression towards self:
☐ biting ☐ head banging

☐ pinching ☐ scratching ☐ slapping

Other (describe):

_____

E. Speech, Language, and Hearing

Hearing:

Does your child hear:
☐ well ☐ poorly ☐ not at all
☐ inconsistently ☐ uncertain

Speech:

At what age did your child first:
Coo and babble _____
Reach to be picked up _____
Use words _____
Use short sentences _____

If your child says less than 20 words, describe some words being used correctly:

_____

Check if any of the following are used?

☐ Picture Exchange Communication

☐ Sign Language

☐ Augmentative Communication Device

Does your child have any speech problems including:
☐ Articulation (pronunciation) errors
☐ Jargon (e.g. "nonsense" words or syllables)
☐ Odd sounds or noises repetitively
☐ Repetitive speech or echolalia
☐ Speech/language delays
☐ Trouble reading "body language" appropriately

Do you have any other concerns about your child's communication skills? ☐ No ☐ Yes, explain:

_____

_____

_____

Does your child mostly communicate by:
☐ Crying ☐ Grunting ☐ Nonspecific gesturing

☐ Pointing with index finger ☐ Using complete sentences
☐ Using phrases ☐ Using single words

☐ Using your hand to obtain desired object
Did your child begin to use words and then stop?

☐ No ☐ Yes, at what age? _____

F. Sensory Skills

Is your child easily over-stimulated? ☐ No ☐ Yes, explain: _____

_____

Sense of touch ☐ No Problems ☐ Avoids some kinds of touch ☐ Seeks out some kinds of touch *Explain as necessary*:	Oral ☐ No problems ☐ Avoids some mouth sensations ☐ Seeks some mouth sensations *Explain as necessary:*
Hearing ☐ No problems ☐ Hypersensitive to some sounds ☐ Ignores some sounds ☐ Inconsistent response to sounds *Explain as necessary:*	Olfactory ☐ No problems ☐ Avoids some smells ☐ Seeks some smells ☐ Atypical/odd smelling behavior *Explain as necessary:*
Vision ☐ No problems ☐ Tracking or depth perception ☐ Over-focusing ☐ Atypical or odd visual behavior *Explain as necessary:*	Vestibular/Proprioceptive ☐ No problems ☐ Avoids some movement/posture ☐ Seeks out some movement/posture *Explain as necessary:*
Pain Threshold ☐ No problems ☐ Higher than expected ☐ Lower than expected ☐ Inconsistent Seeks comfort for injury or pain ☐ No ☐ Yes *Explain as necessary:*	

G. Skills and Interests

☐ No concerns

☐ Atypical use (spinning, lining up) rather than playing ☐ Over-focusing on objects or topics:
☐ Banging/throwing objects rather than playing ☐ Poor imitation skills
☐ Daily time spent with electronics: _____ ☐ _____ (hours) Rituals:
☐ Difficulty keeping attention focused in tasks ☐ Trouble with transitions
☐ Is "on the go" or acts as if "driven by a motor" ☐ Unusual skills of memory
☐ Lack of functional use of objects ☐ Unusual type of interest
☐ Lack of imaginary or pretend play for age
☐ Minimal interest in age appropriate toys
☐ Not playing "peek-a-boo", hide & seek, etc. as expected

Describe your child's favorite play activity/toy/object:

_____

_____

H. Social Development ☐ No Concerns

☐ Aggression
☐ Blames others for own misbehavior or mistakes
☐ Bossiness
☐ Difficulty maintaining social interactions
☐ Difficulty showing emotion
☐ Excessive shyness/clinging to caregiver
☐ Spiteful, vindictive (plots to get even after the fact)
☐ Lack of show and tell behavior
☐ Limited initiation of social contact
☐ Naiveté
☐ Peer conflict
☐ Poor attachment to caregiver
☐ Poor eye contact
☐ Preference for solitary play
☐ Ridicule by peers
☐ Social anxiety

Describe your child's interaction with peers:_____

_____

Your child makes friends:

☐ many opportunities
☐ quickly/easily
☐ with difficulty
☐ rarely
☐ usually wants to play with others
☐ few or rare opportunity
☐ after warms up and is comfortable
☐ actively avoids peers
☐ never
☐ usually wants to be alone

8. CHILD'S MOOD, TEMPERAMENT, AND BEHAVIOR

A. Which of these describes your baby in the first year of life? (*Check all that apply*):

☐ Active	Colicky	Friendly	Intolerant of changes	Quiet
☐ Alert	Cuddly	Happy	Irritable	Stiff
☐ Aloof	Easygoing	Hard to console	Playful	

B. Which of these describes your child now? (*Check all that apply*): ☐ No current concerns

☐ Actions are jeopardizing peers or family
☐ Aggression
☐ Aloof
☐ Always talking
☐ Anxiety
☐ Being overly dramatic
☐ Biting
☐ Bully
☐ Defiant
☐ Disruptive
☐ Easily distracted
☐ Excessive crying
☐ Excessive fearfulness
☐ Excessive responses
☐ Excessive worrying
☐ Flat/bland facial expressions
☐ Forgetful
☐ Foul behaviors/gestures/words
☐ History of abuse/trauma
☐ Homicidal thoughts
☐ Hyperactive
☐ Impulsive
☐ Inappropriate laughing, etc.
☐ Inattentive
  - Inhibited responses
  - Interrupts others
☐ Intolerant of changes
☐ Lack of danger awareness
☐ Lack of fear responses
☐ Mood swings
☐ Negative self statements
☐ Oppositional
☐ Outbursts without obvious reasons
☐ Physical complaints without cause
☐ Poor consolability
☐ Prior suicide attempt
☐ Recurrent nightmares
☐ Refusal to stay in car seat
☐ Running away
☐ Sadness
  - Socially inappropriate
  - Suicidal thoughts
☐ Tantrums
☐ Violent behaviors
☐ Wanders aimlessly

Are you having any other problems with your child's behavior? ☐ No ☐ Yes, explain:

_____

_____

Is anyone else (e.g. school, sitter) having problems with your child's behavior? ☐ No ☐ Yes,

explain:_____

_____

Parenting Style/Response:

☐ Child acts as if they are parent	☐ Positive discipline	☐ Use of praise/builds self esteem
☐ Child does not respond to discipline	☐ Punishment/spanking	☐ Verbal reprimand
☐ Child responds to discipline	☐ Redirection	
☐ Follows through on consequences	☐ Reward system	
☐ Limited use of routines	☐ Structured home/using routines	
☐ Loss of privilege	☐ Time out	

D. Describe your child's:

Strengths:

Challenges:

Special Traits:

9. SCHOOL HISTORY

Please list all schools your child has attended, beginning with any nursery or daycare before kindergarten, and ending with your child's current school.

School	Address	Grade/Class Placement	Dates of Attendance

Previous grade retention? ☐ No ☐ Yes, explain: _____

Have you requested testing from the school? ☐ No ☐ Yes

Is any testing scheduled? ☐ No ☐ Yes, when? _____

■■■ PLEASE ATTACH COPIES OF ANY PREVIOUS TEST RESULTS IF AVAILABLE ■■■

Is your child receiving additional services through the school? ☐ No ☐ Yes, check all that apply:

☐ Self-Contained Special Education ☐ Resource Room ☐ Title/Chap I
☐ Section 504 Placement ☐ Classroom Modifications ☐ Indirect Services
☐ Speech/Language Therapy ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)
☐ Tutoring ☐ Other (Specify)

If your child receives services as a student with a disability, what is the primary disability considered to be?

_____

Are you satisfied with your child's current school performance? ☐ No ☐ Yes

If not, why not? _____

Current grade average: _____

Please answer *Y for yes* and *N for no:*

☐ Can say ABC's ☐ Can read age appropriately
☐ Can count to 10 / 20 / 50 /100 ☐ Can sound out words and letters
☐ Can identify shapes ☐ Likes to color/draw with crayons/pencils
☐ Can identify colors ☐ Enjoys writing
☐ Can identify ABC's to Z ☐ Enjoys working with numbers/math

Can your child follow directions in the classroom? _____

Does your child complete work expected during class time? _____

Does your child bring home correct books/papers to complete assignments? _____

Can you child complete homework independently? _____

Does your child turn in homework assignments and projects on time? _____

Has your child been bullied at school? _____

Any other school concerns:

10. FAMILY HISTORY

Complete the following for all of the mother's pregnancies in order, including any miscarriages or stillbirths:

Name	Date of Birth	Weight at Birth	Length of Pregnancy	Problems at Birth	Physical, emotional, behavioral, or educational problems

Please indicate if any of the child's relatives have had any of the following (ex: parent, sibling, paternal or maternal grandparent, aunts/uncles, cousin, etc.):

Condition **Relationship to child**

☐ ADHD

☐ Autistic Spectrum Disorder

☐ Behavior problems

☐ Cerebral Palsy

☐ Convulsions/Seizures

☐ Deformities/Birth defects

☐ Hearing loss

☐ Language problems

☐ Learning problems Relationship to Child:

☐ Math ☐ Reading ☐ Spelling ☐ Writing ☐ Other

Mental illness Relationship to Child:

☐ Depression ☐ Mood swings ☐ Anxiety ☐ Schizophrenia ☐ Other

☐ Alcoholism ☐ Drug abuse

☐ Physical abuse ☐ Sexual abuse ☐ Domestic violence

☐ Mental retardation

☐ Speech/articulation problems

☐ Tics, motor or vocal

☐ Vision loss

Please note any other relatives with conditions not listed above: _____

_____

Please note any stressors (e.g., deaths, financial worries, marital conflicts, etc.) recently affecting the family:

_____

_____

11. OTHER HISTORY

Please list the names and addresses of other professionals who have worked with you and your family.

	Name	**Complete Address**
Pediatrician		
Family Doctor		
Occupational Therapist		
Speech Pathologist		
Physical Therapist		
Health Department		
Psychologist		
Psychiatrist		
Counselor		
Others (*please specify*) (ie: Orthopedics, neurology, Gastroenterology, cardiology, genetics, endocrinology, hematology, nephrology, pulmonology, dermatology, urology, etc.)		

Please use this space for any other information you feel will be helpful to us in evaluating your child.