MCSD DEVELOPMENTAL HISTORY FORM

Dear Parent or Guardian: *The information on this questionnaire will help us to know whether your child's health is affecting development and it will help us plan for your child's education services.*

Child's name:_____ DOB:_____ Date Completed:_____

Person completing this form:_____ Relationship to child:_____

Other people living at home (Name & Age):_____

_____

Primary Language of child:_____

Child Medical History: *(Please provide details for any YES answers)*

Primary Doctor:_____

Hospital/Clinic Name:_____ Phone Number:_____

Dentist:_____

Clinic Name:_____ Phone Number:_____

- Were there any problems during pregnancy or birth? _____ Yes _____ No
- Did the mother take any medication during pregnancy? _____ Yes _____ No
- Did either parent smoke, drink alcohol or use drugs during pregnancy? _____ Yes _____ No
- At birth, was your child considered premature? _____ Yes _____ No
- Has your child been hospitalized at any time? _____ Yes _____ No
- Does your child have a specific diagnosis? (Ex: asthma, diabetes, down syndrome) _____ Yes _____ No
- Does your child have a specific diagnosis for mental, physical, or emotional issues? _____ Yes _____ No
- Is your child currently taking prescribed medications? _____ Yes _____ No
- Do you have concerns about your child's eating/feeding, nutrition and/or growth? _____ Yes _____ No
- Does your child have any allergies? (Seasonal or foods) _____ Yes _____ No

If you checked YES to any of the above questions, please explain and describe here:_____

_____

_____

Hearing: *(Please provide details for any YES answers)*

- Has your child passed a hearing test? Date:_____Newborn hearing? Date:_____ _____ Yes _____ No
- Do you have concerns about your child's hearing? _____ Yes _____ No
- Is there a history of "childhood" hearing loss in the family? _____ Yes _____ No
- Does your child have a history of frequent/chronic ear infections? How many: _____ _____ Yes _____ No
- Has your child seen an Ear, Nose, or Throat Doctor? _____ Yes _____ No
- Does, or has, your child had ear tubes? When: _____ Yes _____ No
- Does your child:
  - Talk in a load voice? _____ Yes _____ No
  - Turn up the volume on the radio or TV? _____ Yes _____ No
  - Hear you when your back is turned or when you talk to them from another room? _____ Yes _____ No

If you checked YES to any of the above questions, please explain and describe here:_____

_____

_____

Continued on next page…

Vision: *(Please provide details for any YES answers)*

- Do you have concerns about your child's vision? _____ Yes _____ No
- Has your child's vision been checked? When:_____ Doctor:_____ _____ Yes _____ No
- Does your child have any diagnosed vision problems or conditions? _____ Yes _____ No
- Does your child wear glasses? _____ Yes _____ No
- Is there a family history of vision problems or loss in the family? _____ Yes _____ No
- Are there any usual eye movements? (Ex: Eyes turn in/out, doesn't blink, doesn't track objects) _____ Yes _____ No
- Does your child appear clumsy, awkward, run into doors or walls? _____ Yes _____ No
- Does your child have difficulty recognizing people or objects across the room? _____ Yes _____ No

If you checked YES to any of the above questions, please explain and describe here:_____

_____

_____

Communication:

- Do you have concerns about your child's communication skills/abilities? _____ Yes _____ No
- Does your child have answers when you talk to him/her? _____ Yes _____ No
- Can the family understand your child's speech? _____ Yes _____ No
- Can people outside the family understand your child's speech? _____ Yes _____ No
- When you talk to your child, how much does he/she understand? Mark below:
  _____Few words _____Many words and phrases _____Simple directions _____Almost everything I say
- How does your child let you know what he/she wants? Mark all that apply:

  _____Cries _____Makes few sounds _____Makes many sounds _____Uses gestures (Points, Waves, etc.) _____Says a few words

  _____Says many words, but only one at a time _____Uses two or three word sentences _____Uses long sentences

Social:

- What is your overall view of your child's social abilities with peers and adults?_____

  _____

  _____

Professional Consultants:

Please list the below information that your child or family is involved with (Ex: Head Start, DHS, WIC, OHSU, etc.)

Agency or Person **Phone Number** **City**

_____

_____

_____

For your child's age, mark how you feel your child is doing:

Area of Development	My Child is doing OK	I'm a somewhat worried	I'm very worried
Motor Skills: Uses hands, Moves around			
Understanding & Thinking skills: Plays with "age appropriate" toys correctly, Simple problem solving			
Language skills: Has vocabulary, Follows directions, Asks for help			
Speech Skills: You can understand what your child says			
Self-Care Skills: Toileting, Eating, Dressing			
Social Skills: Gets along with "same age" peers and adults			
Vision:			
Hearing:			