PARENT SURVEY

Developmental History Form

This form is intended to be completed by the student’s parent or by someone who has access to early developmental history for the student.

Completed by: _________________________

Relationship to student: _______________

Student’s name: _______________________

Date completed: _______________________  

This form can be faxed to:  
Frances Niarhos, PhD at (615) 322-1326
DEVELOPMENTAL HISTORY QUESTIONNAIRE

To be completed by parent or other caregiver with knowledge of this person’s early development

Student name: _______________________________ Today's date: ______________

Student birth date: ________________________ AGE: ______________

Current school program: ________________________ Year of study: __________

Person completing this: __________________________ Relationship ______________

PRENATAL HISTORY

How was the mother’s health during pregnancy?
( ) Good ( ) Fair ( ) Poor ( ) Don’t Know

Did the mother have any illness or complications during pregnancy with this child? If yes, please describe __________________________________________________________

How old was mother when this child was born? __________

Are you aware if any of the following substances or medications were used during pregnancy?

○ Beer or wine How often? __________
○ Caffeine (coffee, tea, soda, etc.) How often? __________
○ Hard liquor How often? __________
○ Cigarettes How often? __________
○ Other (please specify) ______________ How often? __________

Did the mother have complications during pregnancy? ( ) No ( ) Yes ( ) Don’t Know
If “yes”, please describe:

Was there anything unusual about the delivery or birth? ( ) No ( ) Yes ( ) Don’t Know
If “yes”, please describe:

Was the child born on schedule? ( ) No ( ) Yes
If “no,” how many weeks gestation? ______________

Were there any signs of fetal distress during labor or birth? ( ) No ( ) Yes ( ) Don’t Know
If “yes,” please describe:

Was the delivery: ( ) Normal ( ) Breech ( ) Cesarean ( ) Forceps ( ) Induced

What was the child's birth weight? __________________________
POSTNATAL PERIOD AND INFANCY

Did the child have any medical or physical problems at birth? ( ) No ( ) Yes ( ) Don’t Know
If yes, please describe:

Did the child experience any health problems during infancy? ( ) No ( ) Yes ( ) Don’t Know
If yes, please describe.

Was the child an easy baby, meaning did (s)he cry a lot or did (s)he follow a schedule fairly well?
( ) Very easy ( ) Easy ( ) Average ( ) Difficult ( ) Very Difficult

During childhood, did (s)he have problems with any of the following?

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Speech Articulation</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Gross motor skills</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>(running, climbing, riding a bike)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine motor skills</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>(handwriting, tying shoes, buttoning)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Skills</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

HEALTH STATUS:

Has (s)he had any chronic health problems (e.g., asthma, diabetes, heart condition)?
( ) No ( ) Yes ( ) Don’t Know

If yes, please specify: __________________________________________

Please specify the age of onset of this chronic illness: ___________

Which of the following illnesses/conditions has (s)he had?

○ Head Injury
○ Seizures
○ Chronic Ear Infections
○ Encephalitis
○ Meningitis
○ Other diseases (specify): ________________________

Has (s)he had any serious accidents requiring medical attention, including head injury or an injury when (s)he lost consciousness? ( ) No ( ) Yes ( ) Don’t Know

If yes, please give date and cause of injury.
Has (s)he had any surgeries? ( ) No ( ) Yes ( ) Don’t Know
*If yes, please specify and give date.*

Has (s)he had any hospitalizations? ( ) No ( ) Yes ( ) Don’t Know
*If yes, please specify reason and date.*

Please indicate if prescribed any of the following during childhood (check all that apply):

<table>
<thead>
<tr>
<th>Drug</th>
<th>Duration of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ritalin</td>
<td></td>
</tr>
<tr>
<td>Adderall</td>
<td></td>
</tr>
<tr>
<td>Concerta</td>
<td></td>
</tr>
<tr>
<td>Focalin</td>
<td></td>
</tr>
<tr>
<td>Dexedrine</td>
<td></td>
</tr>
<tr>
<td>Strattera</td>
<td></td>
</tr>
<tr>
<td>Cylert</td>
<td></td>
</tr>
<tr>
<td>Mood Stabilizer</td>
<td></td>
</tr>
<tr>
<td>Antidepressant</td>
<td></td>
</tr>
<tr>
<td>Anti-seizure</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Did (s)he ever had any of the following forms of mental health treatment during childhood? If so, please elaborate:

<table>
<thead>
<tr>
<th>Type of treatment</th>
<th>Age</th>
<th>Duration</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol &amp; Drug Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**SCHOOL HISTORY**

Please summarize the general academic, social, behavioral progress within each of these grade levels. Please describe strengths as well as problem areas or weaknesses in cognitive/academic skills and behavioral control.

<table>
<thead>
<tr>
<th>Toddlerhood/Preschool</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Kindergarten</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elementary School</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Middle School/Junior High</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>High School</th>
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</thead>
</table>

Has (s)he ever been in any type of special educational program? 
( ) No ( ) Yes ( ) Don’t Know  **If yes, please indicate which below:**

- □ Gifted classes  
  During grades: ______________________
- □ Learning disabilities class  
  During grades: ______________________
- □ Behavioral/emotional disorders class  
  During grades: ______________________
- □ Speech and language therapy  
  During grades: ______________________
- □ Other (please specify) __________________________________________

Has (s)he ever been?

- □ Suspended from school  
  ( ) No ( ) Yes ( ) Don’t Know  Number of times: ________
- □ Expelled from school  
  ( ) No ( ) Yes ( ) Don’t Know  Number of times: ________
- □ Retained in grade  
  ( ) No ( ) Yes ( ) Don’t Know  Number of times: ________
Did (s)he exhibit any social or behavioral problems or undue anxiety in childhood? Please explain:
________________________________________________________________________
________________________________________________________________________

Does (s)he have any communication or auditory processing problems? Please explain:
________________________________________________________________________
________________________________________________________________________

Does (s)he have any visual processing or reading problems? Please explain:
________________________________________________________________________
________________________________________________________________________

Does (s)he have difficulty with problem-solving or comprehension? Please explain:
________________________________________________________________________
________________________________________________________________________

CURRENT SOCIAL INFORMATION

How does (s)he get along with his/her brothers/sisters?
☐ No siblings
☐ Better than average
☐ Average
☐ Worse than average

How does (s)he get along with peers?
☐ Better than average
☐ Average
☐ Worse than average
☐ Don’t know

On average, how long does (s)he keep friendships?
☐ Less than 6 months
☐ 6 months - 1 year
☐ More than 1 year
☐ Don’t know