Learning Consultants
9890 Clayton Road • Ladue , MO 63124
Office 314.222.5886 • Fax 314.222.5887

Early Childhood Developmental History Form

Date Completed_____

Child's Name_____ Age_____ Date of Birth_____

Address_____ Phone_____

School_____ Grade_____ Teacher_____

Family

Parent_____ Age_____ Marital Status _____

Education_____ Occupation_____

Place of Employment_____ Phone_____ Cell Phone_____

Parent_____ Age_____ Marital Status _____

Education_____ Occupation_____

Place of Employment_____ Phone_____ Cell Phone_____

Stepparent_____ Age_____ Marital Status _____

Relationship to child_____

Education_____ Occupation_____

Place of Employment_____ Phone_____ Cell Phone_____

Stepparent_____ Age_____ Marital Status _____

Relationship to child_____

Education_____ Occupation_____

Place of Employment_____ Phone_____ Cell Phone_____

Siblings

Name	Age	Relationship	Grade	School/Employment

Family Members and Others in Home

Name	Relation to Child

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Reason for Coming to Learning Consultants

List the names of other professionals with whom you have consulted in the past or are currently seeing. List names, dates of last visit and purpose of consultation and any diagnoses. Bring copies of reports with you.

Within the family or home, what have you done in the past about this area of concern or problem:

What are your expectations of this consultation:

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Pregnancy and Birth History

Adopted? Yes _____ No _____

If yes, please provide any info known about biological parents, and age when child was adopted.

City of Birth _____ Planned Pregnancy _____

Mother's Health _____

_____

Any Medications taken? _____

Labor and Delivery Specifics _____

_____

Birth Weight _____ Full Term _____

Infant's health after delivery _____

_____

Has mother had any miscarriages or stillbirths?

When _____ Causes _____

Early Childhood

Breast fed? _____ Bottle Fed? _____ When weaned? _____

Cuddly or stiff baby? _____

Colic? _____ Rashes? _____

Degree of baby's activity (active, restless, quiet, etc.)

_____

_____

_____

_____

Anxiety with strangers?

_____

_____

_____

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Early Childhood Continued

Unusual circumstances that may have caused a strain (illness, disagreements, separations, relocations, etc.)

_____

_____

_____

_____

During subsequent years:

_____

_____

_____

_____

For Mother:

_____

_____

_____

For Father:

_____

_____

_____

Did anyone supplement parents' care during child's first year:

_____

_____

_____

Describe in detail subsequent child care arrangements:

_____

_____

_____

Describe your child's reactions to day care separations:

_____

_____

_____

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Early Development

Age when crawled? _____ Sat? _____ Walked? _____
First Tooth? _____ Said Words? _____ Sentences? _____
Dominant Hand? _____ When established? _____ Any attempt to change? _____

Toilet training: When and how was it carried out?

_____
_____
_____
_____

Any Relapses?

_____
_____
_____

Are there current bedwetting issues?

_____
_____
_____

Child reactions to:
Separations:

_____
_____
_____

Frustrations and Disappointments?

_____
_____
_____

Discipline: Who Administers? _____ Methods? _____

_____
_____

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Early Development Continued

Do both parents usually agree on disciplining. Explain:

_____

_____

_____

Describe your child's responses to discipline:

_____

_____

_____

Doctors, injections, medicines, temperature taking:

_____

_____

Changes in routines and/or transitions:

_____

_____

_____

Health History

Physical Description:

Height _____ Weight _____ Hair Color _____ Eye Color _____

Physician or pediatrician: _____ Phone: _____

List Illnesses other than normal childhood illnesses (include age of occurrence)

_____

_____

_____

Allergies (include food and medication allergies; any food restrictions)

_____

_____

Any Hospitalizations:

_____

_____

Health History Continued

Current medications taken (include dosage)

_____

_____

_____

Side Effects:

_____

_____

Social-Behavioral Preferences

Child's preferred play partners: Age and Gender (younger, older, same age, alone, adults)

_____

_____

_____

Favorite play activities:

_____

_____

_____

List your child's favorite toy(s).

_____

_____

_____

Describe how your child functions in a group of same age children.

_____

_____

_____

Regular home chores:

_____

_____

_____

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Social-Behavioral Preferences continued

Amount of time spent watching TV, playing computer games or video games:

_____

_____

_____

Describe how your child shares objects with others:

_____

_____

_____

Describe how your child shares information and communicates with adults, especially parents.

_____

_____

_____

Extra-Curricular activities (list both individual and group):

_____

_____

_____

Status of sibling relationships:

_____

_____

_____

Habits

Sleep behavior and/or patterns:

_____

_____

_____

Reactions to darkness:

_____

_____

_____

Habits Continued

Discuss bed time routine:

_____

_____

_____

Describe diet and eating habits:

_____

_____

_____

Is there a pronounced sensitivity to the touch and feel of clothing?

_____

_____

_____

Nervous habits:

Nail biting? _____

Thumb sucking? _____

Security blanket?_____

Other? _____

School Information

Schools attended: (Begin with nursery school.)

School	Years Attended	Grades Completed

Describe current school status:

_____

_____

_____

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School Information Continued

Attitudes:

_____

_____

Grades:

_____

_____

Attention and organization:

_____

_____

Has your child been evaluated by Special School District:

_____

_____

Is your child receiving Special School District services? Please bring a copy of the most recent IEP and evaluation.

_____

_____

Behavior:

_____

_____

Degree of class participation:

_____

_____

Status of school friendships:

_____

_____

Homework:

_____

_____

_____

_____

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Family History

Physical illness:

_____

_____

_____

Emotional disturbances:

_____

_____

_____

Learning problems:

_____

_____

_____

Marital problems:

_____

_____

_____

List 3 characteristics that you find admirable in your child and would not like to change:

1) _____

_____

_____

2) _____

_____

_____

3) _____

_____

_____

List other strengths and skills your child has:

_____

_____

_____

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List special talent/skills your child has:

_____

_____

_____

List 3 characteristics in your child's behavior that you would like to change:

1) _____

_____

_____

2) _____

_____

_____

3) _____

_____

_____

_____ _____

Signature(s) of Informant(s) Date