Referred by: _____

Christian Educational Therapy's ~ Developmental History

Client's Name: _____ Birthdate: _____ Today's Date: _____

Home Address: _____

City, State, ZipCode: ____++++++_____

Home Phone: _____ Wk. Phone: _____

Cell Phone: _____ Email: _____

Mother's Name: _____ Living at home with child: Yes ____ No _____

Father's Name: _____ Living at home with child: Yes ____ No _____

Religious Preference: _____ (Optional and for conversational purposes only)

Brothers or Sisters (Please list name and ages):

_____

_____

_____

School Child attends: _____ Home Schooling: Yes_____

School Phone #:_____ Principal's Name:_____ Present Grade: _____

Was your child ever retained? Yes___ No ___ If yes, what grade? _____

Was your child ever tested? Yes___ No____ If yes, through what system? (Please name the system of either the School District or private company)

_____

Has your child ever had any special tutoring? If so where:_____

Did your child ever have an Individual Educational Program (IEP)? Yes_____ No _____ Not sure _____

Reasons for Psycho-educational Testing or Concerns:

_____

_____

_____

_____

_____

I. Newborn Infant Difficulties (Check all that apply)

___ Born with cord around neck

___ Injured during birth

___ Had trouble breathing

___ Got Yellow (Jaundice)

___ Turned blue (cyanosis)

___ Had seizures

___ Needed Oxygen

___ Went into ICU

___ Was in the hospital more than 7 days

___ Born with a heart defect

___ Born with other defect(s) If yes, where are the defects: _____

Apgar score of _____

___ Baby's birth weight _____ lbs. ___ oz.

Please list any other difficulties that may have occurred, or that you have noticed in your child's infant/toddler years (Ages 0-5):

II. Health Condition Overall:	Never	0-1 yr.	2-5 yrs.	6-10 yrs.	11-15 yrs.	16+
Ear infections						
Meningitis						
Seizures						
High fevers (over 103 F. or 39 C.)						
Pneumonia						
Trouble with ears or hearing						
Trouble with eyes or seeing						
Surgery						
Hospitalizations						
Lead poisoning						
Heart problems						
Allergies to food						
Allergies to environment						
Anemia						
Poisoning or overdose						

Please give reasons for hospitalizations or surgery:

Please share if your child had any prolonged illnesses. If they had to take medication over a long period of time, what was the medication and were there any side effects?

III. Functional Conditions in Early Life:	Never	0-1 yr.	2-5 yrs.	6-10 yrs.
Sleeping problems				
Overactivity				
Head Banging				
Temper Tantrums				
Self-destructive behavior				
Crying often and easily				
Irritability				
Extreme reactions to noise or sudden movement				
Clingy				
Tendency to make odd sounds, grunts, or snorts				
Tendency to twitch or jerk arm(s) or head often				
Breast-fed				
Trouble getting along with peers				
Trouble listening to authority and following rules				
Eating difficulties				
Low self image or esteem				
Possessive with parents				

IV. Does your child have any repetitive movements or interests in certain objects or having things done in a certain way at an extreme level of occurrence? If yes, please explain:

V. Does your child interact with others with good social skills? If yes or no, explain what you observe?

VI. Did your child attend a preschool/nursery school? If yes, were there any difficulties with your child's behavior? If yes, please briefly share:

VII. If your child attended a preschool/nursery school, were there any difficulties seen where learning was involved? Please explain:

VIII. Family History	Child's Father	Child's Mother	Child's Brother(s)	Child's Sister(s)	Others: (specify)
Hyperactive					
Trouble learning to read					
Trouble with Mathematics					
Trouble with writing					
Speech difficulties					
Behavior problems in school					
Kept back in school					
An honor student					
Mental retardation					
Depression					
Drug or alcohol difficulties					

IX. Early Educational Experience	Did Well	Some Problems	Serious Problems	Cannot Say
Learning to read in 1st-2nd grade				
Reading level in 3rd-6th grade				
Learning Mathematics 1st-3rd grade				
Learning Mathematics 4th-6th grade				
Learning to spell in 1st-3rd grade				
Learning to spell in 4th-6th grade				
Learning to tell time				
Learning to follow rules				
Learning to write in handwriting or printing				
Learning to write words or sentences				
Getting homework done				
Paying attention in the classroom				
Being disruptive in class				
With computer work				
Understanding spoken directions				
Understanding written directions				

X. From the chart above, if your child had either "some problems" or "serious problems", could you use this space to define what you observed? (Please feel free to use the back of this page as well)

XI. Attention-Inattention	Definitely Applies	Applies Somewhat	Doesn't apply
Can concentrate for only a short time unless interested			
Misses important details to what she/he is being told			
Seems to tire easily			
Often seems lethargic or tired			
Quickly does things to finish versus being careful			
Has trouble memorizing things in school			
Memorizes only for the day, forgets tomorrow			
Doesn't notice when he/she makes mistakes			
Is a poor listener			
Seems to look around or stare a lot , daydreams			
Forgets to hand in assignments			
Restless; seems bored			
Is unorganized			
Seems to have too much energy			
Fidgety; has difficulty sitting still			
Gets into trouble without really meaning to			

XII. Please list your child's strengths and abilities, talents and gifts:

XIII. Please write any other insights that you feel would be helpful to provide greater understanding of your child's needs: (Feel free to add more and attach to this Developmental History or use the back of this page.)