❖ **Please contact the school if you would prefer to discuss developmental history in person.**

Confidential

DEVELOPMENTAL HISTORY
DEDHAM PUBLIC SCHOOLS

Child's name: ________________________________	Date: ____________________
Address: ___________________________________	Birth Date: ________ Age:__
School: ____________________________________	Phone: __________________
Teacher: ___________________________________	Grade: _____ Sex: O M O F

Person(s) Completing Form: ____
Relationship to Student: ____
Address: ______________________________ Phone: (h) ___________ (w) ___________

Who referred this student? ____
Reason for referral: ____
____
____

Mother's Name: ____
Address: ____
Home Phone: _________________________ Work Phone: ________________________
Occupation: ____ Full Time / Part Time
Employer: ____

Father's Name: ____
Address: ____
Home Phone: _________________________ Work Phone: ________________________
Occupation: ____ Full Time / Part Time
Employer: ____

Siblings
Name: ___________________ Age: ___ School: ___________ Living at Home? ______
Name: ___________________ Age: ___ School: ___________ Living at Home? ______
Name: ___________________ Age: ___ School: ___________ Living at Home? ______
Name: ___________________ Age: ___ School: ___________ Living at Home? ______

With whom does the child live? ____
How long in current living situation? ____
Primary Caregiver: ____
Address: ____
Home Phone: _________________________ Work Phone: ________________________
Occupation: ____ Full Time / Part Time

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Does this child have any stepparents? *No / Yes*
Name: ____
Address: ____

Name: ____
Address: ____

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Describe child (interests, strengths, weaknesses, personality, etc.) below:

How do you think this child feels about school? (Include what things they enjoy and/or are good at, academic or otherwise, in the course of their school day.)

Birth date: ____________________ Place: ________________________
Birth weight: ______ lbs ______ oz Length of pregnancy ____________ weeks

Conditions of pregnancy & delivery (complications, unremarkable, etc.):

Milestones:
Talking: __________ Walking __________ Toilet Trained __________

Did this child experience any of the following difficulties?

Walking difficulty No / Yes ____________________________
Unclear speech No / Yes ____________________________
Feeding problem No / Yes ____________________________
Underweight problem No / Yes ____________________________
Overweight problem No / Yes ____________________________
Colic No / Yes ____________________________
Difficulty sleeping / night terrors No / Yes ____________________________
Difficulty riding bicycle No / Yes ____________________________
Difficulty skipping No / Yes ____________________________
Difficulty throwing/catching No / Yes ____________________________

Does this child do the following independently:
Sleep in own bed? No / Yes ____________________________________
Dress self? No / Yes ____________________________________

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Health:

Please list any significant illnesses/operations/emergency room visits Age

____ ______
____ ______
____ ______
____ ______

Child's pediatrician: ____

Has this child been on long-term medication (more than three months) *Yes / No*
If yes, when? ______________________ Name of medication ________________
Reason for this medication: ____
Is this child currently on medication? *Yes / No*
If yes, name of medication: ___________________ Reason: _________________

Has this child ever experienced:

Allergies? *Yes / No* ____
Ear infections? *Yes / No* ____
Hearing problems? *Yes / No* ____
Ear tubes? *Yes / No* ____

Has this child ever been involved in counseling or therapy? *No / Yes*
Reason for counseling: ____

Has this child ever been involved with any other specialists? *No / Yes*
If yes, please explain ____
____

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Childcare/Educational History

Childcare? *No / Yes* If yes, how long? ________________ Where?____________
Preschool? *No / Yes* At what age? _____ Days per week? _____ Where? ____________
Any concerns in preschool? ____
____

Kindergarten? *No / Yes* Where? __________________________ Half-day/Full-day
Any concerns in kindergarten? ____
____

Has this child had any separation issues at home or school? ___________________
____
____

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Peer relationships:

Does your child have friends his/her own age? *Yes / No*

What role does this child take on with peers (leader, aggressor, passive, etc.)? ________
____

Is this child involved in any organized group activities? If so, please list: ____________
____
____

Family history of learning difficulties or learning disabilities? *Yes / No*
If yes, please explain below:

Any significant life changes or losses? *Yes / No*
If yes, please explain below:

Concern(s) about child's academic, social, and/or emotional development: