*Developmental History Form*

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| --- | --- | --- | --- |
| **Service User Name** |  | **D.O.B** |  |
| **Name of the person completing the form** |  | **Relationship to service user** |  |
| **Telephone Number** |  | **Email Address** |  |
| **Address** |  | **Date** |  |

**FAMILY INFORMATION**

**Mother/Guardian Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation when service user was a child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father/Guardian Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation when client was a child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parents at time of client being a child were (married/not married/separated/never together etc.):**

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**Sibling Information:**

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| --- | --- | --- | --- | --- | --- |
| **Name of sibling** | **Sex** | **Age** | **Same Mother?** | **Same Father?** | **Lived with client during childhood?** |
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| How well did your child get along with his/her siblings when they were children?  Did they play together? - What did they play? |  |
| What languages were spoken at home? |  |

**FAMILY PSYCHIATRIC HISTORY**

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| --- | --- |
| **Condition/Disorder** | **Family Member And Details** |
| Autism Spectrum Condition |  |
| ADHD/ADD |  |
| Dyslexia/ Learning Difficulty |  |
| Dyspraxia |  |
| Learning Disability |  |
| Special Education |  |
| Epilepsy/Seizure Disorder |  |
| Genetic Condition |  |
| Anxiety |  |
| Depression |  |
| Psychosis or Schizophrenia |  |
| Other Mental Health Diagnoses |  |
| Substance Abuse |  |
| Suicidal Ideation/ Attempt |  |
| Police involvement – prison sentences |  |

**PREGNANCY AND BIRTH HISTORY**

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| --- | --- | --- | --- |
| Mother’s age at birth |  | Father’s age at birth |  |
| Pregnancy full term?  If no when: |  | | |
| Multiple birth?  Identical? |  | | |

**Mother’s health during pregnancy:**

|  |  |
| --- | --- |
| Health problems during pregnancy? |  |
| Medications taken |  |
| Drug or alcohol use during pregnancy? If yes please specify: |  |

**Labour and Delivery**:

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| --- | --- |
| List any problems during labour and delivery: | |
| Birth weight if known: |  |
| Was the child born with any birth defects? If yes, explain: |  |

**Newborn period:**

|  |
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| Was the child healthy as a newborn?  **Yes  No** If not, please describe the problems and treatment: |
| Did the child require treatment in a newborn intensive care unit or any special care immediately after birth?  If yes explain: |

**Developmental History**

**Social Development**

Please expand if possible and give examples:

From birth to one year:

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| --- | --- |
| Did they enjoy cuddling and being close? |  |
| Were they ever irritable or did they cry a lot? |  |
| Did they look at you? |  |
| Did they react when you called their name? |  |
| Did they look at a toy if you shook it? |  |
| After 6 months did they smile at you/ copy your facial expressions? |  |

In the first four years of life:

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| --- | --- |
| Did you notice any delays in the client’s social development? |  |
| Did they have frequent tantrums or ‘meltdowns’ |  |
| Did they have difficulties being separated from you? |  |
| Did they cry frequently? |  |
| Did they play with other children? |  |
| Did they like to come and speak with you? Did they tell you about their experiences? |  |
| Did they approach you to ask for things? |  |
| Did they point at things to show you? |  |
| Did they come to you to be comforted when they were hurt or upset? |  |

**Speech and Language Development**

Please expand if possible and give examples:

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| Did they ever have any input from a Speech and Language Therapist?  How long – what for? |  |
| Did they have any problems with hearing? |  |
| By the age of 3 months: Did they show interest in sound? |  |
| By the age of 6 months: Did they ‘babble’ - make baby noises, try to copy you? |  |
| By the age of 12 months: Did they understand questions/instructions  Such as: “would you like carrots?” “Go and get your shoes” |  |
| By the age of 12 months: Were they speaking their first words – simple words?  (Regardless of pronunciation) |  |
| By the age of 2 years: Were they using short phrases and sentences?  (e.g. “Car is broken/ I am hungry”) |  |
| After the age of 4 years: Did they have any problems with their speech?  e.g. a stammer, lisp, articulation errors – please specify |  |
| By the age of 4 years: Could they tell you about their day? Could they tell you a story using a book? |  |
| Did they ever become frustrated when they couldn’t communicate something to you? |  |
| As they got older could they understand non-literal language and idioms? (e.g. “) |  |
| Any other issues with speech and language development? |  |

**Motor Development**

Please expand if possible and give examples:

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| By the age of 6 months: Could they turn over? |  |
| By the age of 9-12 months: Could they sit up unsupported? |  |
| By the age of 9-12 months: Could they crawl? |  |
| By the age of 12 months: Could they stand up? |  |
| By the age of 12-18 months: Could they walk alone? |  |
| By the age of around 7 years: Could they run and ride a bike without stabilisers? |  |
| Were they clumsy? Did they bump into things or fall over frequently? |  |
| Did they have problems with skills such as tying shoe laces, writing, doing buttons and zips, using cutlery? |  |

**Development of Play:**

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| --- | --- |
| What did they play with? |  |
| Did they pretend dolls/teddies or other items were alive? |  |
| Did they do anything else with toys? (e.g. dropping toys, bashing, holding, lining them up) |  |
| Was their play repetitive? |  |
| Did the client engage in pretend play? E.g. pretending to be a family/doctor/cashier or tea parties. |  |
| If playing imaginatively did they play with others? Could they share their ideas/ did they copy someone else? |  |
| Did they play with *objects as something other than what they were?* (e.g. pretending a banana was a phone or a hairbrush a microphone) |  |

**Daily Living**

Please expand and give details and examples.

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| --- | --- |
| At what age where they toilet trained? Was there any bed wetting or soiling? |  |
| Did they have any problems with bathing and learning how to wash themselves? |  |
| Did they put too much food in their mouth? |  |
| Did they learn to tell the time on a clock with hands? |  |

**Sensory Processing:**

Please expand and give details and examples.

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| Did they have any difficulties tolerating food textures?  Any gagging or vomiting? |  |
| Did they prefer food separated on the plate? (e.g. sauce in a bowl, pasta on the plate) |  |
| Did they have any problems tolerating certain clothing materials? |  |
| Did they have difficulties being touched by people they knew? |  |
| Were they over or under sensitive to pain? |  |
| Did they have any problems going to busy, noisy places like supermarkets or public transport? |  |
| Did they ever use ‘stimming’ behaviours? *Hand flapping, rocking, tapping.* |  |
| Any other sensory sensitivities? |  |

**Significant LOSS of an acquired skill or skills (not just a delay)?**

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| For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then  stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for  many months and then just stopped speaking altogether or began using only single words occasionally)  Please give details: |

**MEDICAL HISTORY**

As a child:

|  |  |
| --- | --- |
| Any serious injuries?  Including head injuries |  |
| Sleep problems? |  |
| Vision problems? |  |
| Hearing difficulties? |  |
| Other medical conditions? |  |
| Any Mental Health conditions? |  |
| Did they have any problems with puberty? |  |
| Hypermobility? |  |

**Specialised neurological or genetic tests:**

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| --- | --- |
| Any neurological or genetic testing?  (EEG, CT, MRI, PET scan, Chromosomal analysis/genetic testing) | **Yes No**  **Details and results if yes:** |

**List all hospitalisations and surgeries for the client, include overnight stays (medical or behavioral)**

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| --- | --- | --- |
| **Reason for hospitalisation/surgery** | **Age** | **Length of stay** |
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**Allergies** (to medications, foods, environmental antigens, etc.)

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| --- | --- |
| **Source (medication, food, etc.)** | **Nature of reaction (hives, trouble breathing, etc.)** |
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**EDUCATIONAL HISTORY**

Please expand and give details and examples

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| --- | --- |
| Did they attend mainstream school throughout? |  |
| Did they have an educational statement or Education Health Care Plan (EHCP)? |  |
| Did they receive any educational support?  Teaching Assistants, specialist provision, smaller class size etc. |  |
| Did teachers ever raise concerns about anything? |  |
| What was the feedback from the school? (e.g. Well behaved/quiet/disruptive etc.) |  |

**Social and Behavioral Functioning**

Please expand and give details and examples

|  |  |
| --- | --- |
| Do you remember them having friends at school?  How many? |  |
| Did they have any difficulties with their peers? |  |
| Did they like to be with friends? |  |
| Did they prefer to be alone? |  |
| Did they have friends round to play or go to friends’ houses? |  |
| Did they go to parties? Did they enjoy them? |  |

**Recreational Interests**

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| --- | --- |
| Did they have any hobbies? |  |
| Did they play any sports? |  |
| What would they do with their free time? |  |
| Did they like to do the same thing repetitively? |  |

**Coping with change**

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| How did the client cope with any major changes during childhood? *For example, moving house, moving school, going on holiday* |
| Did the client ever have difficulty coping with changes in their routine as a child? *For example, changes in meal times / location, changes in route when travelling to school* |

**Personal Strengths**

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| --- | --- |
| What were they good at as a child? Any specific skills or strengths? |  |

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| Any additional comments: |