Children's Hospital New Orleans
200 Henry Clay Avenue
New Orleans, Louisiana 70118
Ph: 504.896.9484; Fax: 504.894.5115

DEVELOPMENTAL HISTORY

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

Form completed by: _____ Relationship to child: _____

Date form completed: _____

General Information

Child's Name: _____ Gender: ☐ Male ☐ Female
First *Middle* *Last*

Date of Birth: _____ Age: _____

Child's Address: _____
Number and Street City State Zip

Home phone: _____ Ethnic/Cultural Background (optional) _____

Primary language spoken in the home: _____ Other language spoken in the home: _____

Referral Information

Who referred you to the clinic/How did you hear about the clinic? _____

If you **DO NOT want us to send a copy of our report to the referral source, please mark here ☐

Current Concerns

What is the main reason for your child's referral today? _____

_____

How long has your child had these problems? _____

_____

What are you hoping to achieve at the completion of this evaluation? _____

_____

SYMPTOM SURVEY

Below is a list of items and behaviors that commonly describe children. Please circle all behaviors that your child currently exhibits or has exhibited in the past. Please add any helpful comments next to the items.

1) PROBLEM SOLVING

Current	Past	
_____	_____	Difficulty figuring out how to do new things
_____	_____	Difficulty making decisions
_____	_____	Difficulty planning ahead
_____	_____	Difficulty solving problems a younger child can do
_____	_____	Disorganized in his/her approach to problems
_____	_____	Difficulty understanding explanations
_____	_____	Difficulty doing things in the right order (sequencing)
_____	_____	Difficulty verbally describing the steps involved in doing something
_____	_____	Difficulty completing an activity in a reasonable period of time
_____	_____	Difficulty changing a plan or activity when necessary
_____	_____	Is slow to learn new things
_____	_____	Difficulty switching from one activity to another activity
_____	_____	Easily frustrated
_____	_____	Other problem solving difficulties: _____

2) SPEECH, LANGUAGE, AND MATH SKILLS

Current	Past	
_____	_____	Difficulty speaking clearly
_____	_____	Difficulty finding the right word to say
_____	_____	Not talking
_____	_____	Rambles on and on without saying much
_____	_____	Jumps from topic to topic
_____	_____	Odd or unusual language or vocal sounds
_____	_____	Difficulty understanding what others are saying
_____	_____	Difficulty understanding what he/she is reading
_____	_____	Difficulty writing letters or words

_____ _____ Difficulty reading letters or words

_____ _____ Difficulty with math

_____ _____ Other speech, language, or math problems: _____

3) SPATIAL SKILLS

Current Past

_____ _____ Confusion telling right from left

_____ _____ Has difficulty with puzzles, Legos, blocks, or similar games

_____ _____ Problems drawing or copying

_____ _____ Doesn't know his/her colors

_____ _____ Difficulty dressing (not due to physical difficulty)

_____ _____ Problems finding his/her way around places he/she has been to before

_____ _____ Difficulty recognizing objects

_____ _____ Seems unable to recognize facial or body expressions of disapproval or emotions

_____ _____ Gets lost easily

_____ _____ Other spatial problems: _____

4) AWARENESS AND CONCENTRATION

Current Past

_____ _____ Easily distracted by: Sounds _____ Sights_____ Physical sensations _____

_____ _____ Mind appears to go blank at times

_____ _____ Loses train of thought

_____ _____ Difficulty concentrating on what others say, but can sit in front of a TV for long periods

_____ _____ Attention starts out OK but can't keep it up

_____ _____ Other attention or concentration problems:_____

5) MEMORY

Current	Past	
_____	_____	Forgets where he/she leaves things
_____	_____	Forgets things that happened recently (e.g., last meal)
_____	_____	Forgets things that happened days/weeks ago
_____	_____	Forgets what he/she is supposed to be doing
_____	_____	Forgets names more than most people do
_____	_____	Forgets school assignments
_____	_____	Forgets instructions
_____	_____	Other memory problems: _____

6) MOTOR AND COORDINATION

Current	Past		Check the side of the body this occurs on: Right Side	Left Side	Both Sides
_____	_____	Fine motor control problems (using a pencil or crayon)	_____	_____	_____
_____	_____	Clumsy	_____	_____	_____
_____	_____	Weakness	_____	_____	_____
_____	_____	Tremor	_____	_____	_____
_____	_____	Muscle are tight or spastic	_____	_____	_____
_____	_____	Odd movements (posturing, peculiar hand movements, etc.)	_____	_____	_____
_____	_____	Drops things more than most children			
_____	_____	Has an unusual walk			
_____	_____	Balance problems			
_____	_____	Other motor or coordination problems: _____			

7) SENSORY

Current	Past		Check the side of the body this occurs on: Right Side	Left Side	Both Sides
_____	_____	Needs to squint or move closer to page to read	_____	_____	_____
_____	_____	Problems seeing objects	_____	_____	_____
_____	_____	Loss of feeling	_____	_____	_____
_____	_____	Problems hearing sounds			

(Sensory Continued)

_____ _____ Difficulty telling hot from cold

_____ _____ Difficulty smelling odors

_____ _____ Difficulty tasting food

_____ _____ Overly sensitive to: Touch_____ Light_____ Noise_____

_____ _____ Other sensory problems: _____

8) PHYSICAL

Current	Past		How Often?
_____	_____	Frequently complains of headaches or nausea	_____
_____	_____	Has dizzy spells	_____
_____	_____	Has pains in joints Where? _____	
_____	_____	Excessive tiredness When?:_____	
_____	_____	Frequent urination or drinking	
_____	_____	Other physical problems: _____	

9) BEHAVIOR

Current	Past		Current	Past	
_____	_____	Aggressive	_____	_____	Nervous
_____	_____	Attached to things, not people	_____	_____	Nightmares, night terrors, sleepwalks
_____	_____	Toileting Accidents (day / night)	_____	_____	Quiet
_____	_____	Unusual behavior	_____	_____	Resists change
_____	_____	Bowel movements in underwear	_____	_____	Risk-taking
_____	_____	Dependent	_____	_____	Self-mutilates
_____	_____	Depressed	_____	_____	Self-stimulates
_____	_____	Eating habits are poor	_____	_____	Shy and withdrawn
_____	_____	Emotional	_____	_____	Sleeping habits are poor
_____	_____	Fearful	_____	_____	Swears a lot
_____	_____	Immature	_____	_____	Unmotivated
_____	_____	Other unusual behavior: _____			