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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 qwt"qhkeg/How did you hear about qwt"qhkeg? ____

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?____

____

U[O RVQO 'UWTXG["

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) <u>SPATIAL SKILLS</u>

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) <u>AWARENESS AND CONCENTRATION</u>

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

Check the side of the body this occurs on:

Current	Past		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

Check the side of the body this occurs on:

Current	Past		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: ____

Does your child currently (within the past 6 months) display any of the following behaviors frequently?

These behaviors should occur more frequently than in other children the same age

Fainting, falling	Anxiety	Low frustration tolerance	Physical aggression
Clumsiness	Unusual fears	Impulsivity	Stealing
Shy, timid	Avoidance	Hyperactivity	Use of profanity
Social Isolation	Laziness	Attention seeking	Skipping school
Lack of confidence	Obsessive-compulsive behaviors	Irritability	Fire setting
Low self-esteem	Stereotyped/repetitive behaviors	Temper tantrums	Destructiveness
Crying episodes	Memory loss	Oppositional behavior	Cruelty to animals
Unhappiness	Poor concentration	Noncompliance	Gang Involvement
Concern with weight	Short attention span	Defiance	Cigarette use
Sleep problem	Distractibility	Lying	Alcohol / Substance use
Other:			

Overall, the child's symptoms have developed: _____ Slowly _____ Quickly

The symptoms occur: _____ Occasionally _____ Often

Over the past 6 months the symptoms have: _____ Stayed about the same _____ Worsened

Services/Interventions Sought Previously

Medical Evaluation	Neuropsychological Assessment	Educational Testing	Psychiatric Exam
Medication	Neurological Exam	Speech/Language Therapy	Special Education
School Modifications	Psychological Counseling or Therapy	Occupational/Physical Therapy	Tutoring

Has your child had any of the following forms of psychological treatment? If so, how long did it last?

Individual psychotherapy	Yes	No	Duration of therapy? ___________________________
Group psychotherapy	Yes	No	Duration of therapy? ___________________________
Parenting classes	Yes	No	Duration of classes? ____________________________
Residential treatment	Yes	No	Duration of placement? _________________________

Is your child currently receiving psychological treatment? If so, with whom and how often? ______________________

____

What else have you tried to do to help your child with these problems, and how effective were these interventions?

____

____

Family History

(Please circle: Birth, Adoptive, or Foster)
Birth / Adoptive / Foster Mother's Name: ______________________ Age _____ Education (Yrs) _______
Address (if different from child's) ____
____
Occupation: ______________________ Employer ______________________
Work Phone: ______________________ Home Phone: ______________________

Birth / Adoptive / Foster Father's Name: ______________________ Age _____ Education (Yrs) ________
Address (if different from child's) ____
____
Occupation: ______________________ Employer ______________________
Work Phone: ______________________ Home Phone: ______________________

Stepmother's Name: ______________________________Age _____ Education (Yrs) _______
Address (if different from child's) ____
____
Occupation: ______________________ Employer ______________________
Work Phone: ______________________ Home Phone: ______________________

Stepfather's Name: ______________________________Age _____ Education (Yrs) __________
Address (if different from child's) ____
____
Occupation: ______________________ Employer ______________________
Work Phone: ______________________ Home Phone: ______________________

Other Guardian's Name: ___________________________Age _____ Education (Yrs) __________
Address (if different from child's) ____
____
Occupation: ______________________ Employer ______________________
Work Phone: ______________________ Home Phone: ______________________
Relationship to child: ____

Hquvgt 1Cfqrvkxg'Kphqto cvkqp<'

(Please complete this information only if the child has ever been adopted or placed in foster care)

What age was the child first placed in foster care? ___________

Why was the child placed in foster care? ____

____

Who has legal custody of the child? ____

Name of child's social worker: ____ Phone number _____________________

Social worker address: ____

Has the social worker provided consent for this evaluation? ☐ Yes ☐ No

(If YES, please attach authorization; If NO, please request authorization from county social services)

Is the child adopted? ☐ Yes ☐ No If yes, specify country of origin if international _____________________________

Age when child was first in home: ______________ Date of legal adoption: _____________________________

If the child was adopted, do they know they were adopted? ☐ Yes ☐ No

How many different foster care / adoptive placements has the child experienced? ___________________________

What type of placements has the child experienced (e.g., orphanage, foster home, group home, shelter care, kinship home, hospitalization, etc.): ____

____

Does the child have any contact with biological parents? ☐ Yes ☐ No

If yes, with whom, how often, are the visits supervised, how does the child respond after the visits?

____

____

If the child is not yet adopted, is there a plan for this to happen? ☐ Yes ☐ No

If yes, what is the time frame? ____

How has the child adjusted to foster care / adoption? ____

____

Nkuv'cnn'rgqrng'y kj 'y j qo 'vjg'ej kf 'ewttgpvn{ 'tgukfgu<

Names of Household Members	Age	Gender M / F	Relationship to Child	Highest Grade Completed
______________________	______	______	______	______
______________________	______	______	______	______
______________________	______	______	______	______
______________________	______	______	______	______
______________________	______	______	______	______
______________________	______	______	______	______

If any brothers or sisters are living outside the home, list their names, ages, where they are living, and why they are no longer in your home: ____

____

Are parents separated or divorced: ☐ No ☐ Yes (describe below)

When did you separate/divorce? ______________________________

Who has physical custody of child? ______________________________

Who has legal custody of the child? ______________________________

How often does the other parent see this child? ______________________

Have there been any major changes within the family life or the child's living situation that have affected your child's development (e.g., deaths, moves, divorces, loss of job, etc)? ☐ No ☐ Yes (describe below)

Event	Date	Child's Age

Pre-Natal Period

Did mother receive prenatal care during the pregnancy? ☐ Yes ☐ No Starting in which month? __________

Number of the following the mother of the child has had (including the child being evaluated):
Pregnancies _____ Miscarriages _____ Premature births _____

Did mother have any of the following during or immediately before/after the pregnancy (check all that apply)

☐ Emotional stress
☐ Toxemia
☐ Excessive swelling (edema)
☐ Flu
☐ Vaginal bleeding (when? _______)
☐ Epilepsy/seizure
☐ Other (Rh incompatibility, etc.)
☐ Infections (cold, flu)
☐ Anemia
☐ Measles/German measles
☐ High blood pressure
☐ Strep throat
☐ X-ray studies
☐ Diabetes
☐ Preterm labor/bedrest
☐ Abnormal weight gain
☐ Excessive vomiting
☐ Kidney disease
☐ Threatened miscarriage
☐ Fever
☐ Other virus
☐ Maternal injury. Describe: ____
☐ Operation/hospitalization during pregnancy. Reason: ______________________________

Were any of the following used during pregnancy? (check all that apply)

☐ Prescribed medications. (Please specify): ______________________ For: _______________
☐ Tobacco
☐ Amphetamines
☐ Cocaine
☐ Marijuana
☐ Heroin
☐ Alcohol
☐ Methamphetamines
☐ Methadone
☐ Other (specify) ________________

Birth History

Age of mother at birth? ____________ Age of father at birth? ____________

Was infant born full term? ☐ Yes ☐ No Number weeks gestation ____________

Birth weight: _____ lbs. _____ oz. Apgars (if remembered) _____ at 1 min _____ at 5 min.

Type of Labor Onset: Induced Spontaneous

Type of Birth: Vaginal C/Section (Planned? Yes No - Emergency? Yes No)
Vaginal Birth after C/Section (VBAC) ☐ With instruments (forceps)

Type of Anesthesia: Gas Spinal Local ☐ None

Baby's Presentation: Breech Head Transverse (sideways)

Please check the following problems that may have occurred during labor:

Yes	No		Yes	No	
		Toxemia/eclampsia			Fetal distress
		Maternal fever			Medications used (please specify): ______________

Length of active labor: _____ hours. Describe any complications during delivery:______________________________
____

Post-Delivery Period

Check which of the following problems may have occurred after the child's birth and explain the amount and treatment in the space below:

Yes	No		Yes	No	
		Trouble breathing			Jaundice
		Cord around the neck (# of times ____)			Poor feeding
		Knot in cord			Required a blood transfusion
		Seizures			Vomiting / reflux
		Hemorrhage (bleeding) in head			Floppy muscle tone
		Hydrocephalus (water on the brain)			Incubator care
		Cyanosis (turned blue)			Infection
		Need for ventilation			Fever

Please explain all "Yes" answers:

____

____

Did infant require X-ray/ CT scan? ☐ No ☐ Yes
Was infant placed in the NICU? ☐ No ☐ Yes If yes, how long: _________

Length of stay in hospital: Mother: __________ days. Infant: _________ days.

Developmental History

Was any of the following present in your baby during the first few years of life? If so, please describe:

Yes	No		Yes	No	
		Did not enjoy cuddling			Was not calmed by being held or stroked
		Difficult to comfort			Excessive restlessness
		Excessive irritability			Frequent head banging
		Difficult feeding			Sleeping difficulties
		Extremely passive			Early learning problems
		Temper tantrums			Withdrawn behavior
		Convulsions			Poor eye contact
		Colic			Unable to separate from parent
		Destructive behavior			Failure to thrive/poor weight gain
		Breathing problems			

Was your child adaptable, easy to please and easy to discipline as an infant and toddler? ☐ Yes ☐ No
If no, please describe: ____

____

As an infant and toddler, was your child interested in social contact (eye contact, social smile, showing things, sharing experiences)? ☐ Yes ☐ No If no, please describe: ____

____

As an infant and toddler, describe your child regarding his/her ease of self-regulation (e.g., ability to settle down at night, calm self when upset, etc.)? ____

____

Please list the approximate age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A. If unsure, please write DK.

Age:		Age:	
________	Smile in response (social smile)	________	Know primary colors
________	Sit independently	________	Say the letters of the alphabet
________	Crawl independently	________	Print first and last name
________	Walk independently	________	Tie shoes
________	Say “mama” or “dada” specifically	________	Snap, zip, button clothing
________	Say 1st word other than “mama” or “dada”	________	Began to read
________	Put two words together	________	Toilet trained (urine)
________	Put 4-5 sent. together to relate an experience	________	Toilet trained (bowel)
________	You understood 100% of what child said		

Has your child ever lost skills that at one time he/she was able to perform? ☐ Yes ☐ No

If yes, please explain: ____

Are there any concerns related to toilet training? ☐ Yes ☐ No

If yes, please describe: ____

Medical/Health History

What was the date your child’s last physical exam? ________________________

Child’s physician________________________ Phone number ________________________

Vision problem? Yes No Date of last vision exam: ________________________

Hearing problem? Yes No Date of last hearing exam: ________________________

Appetite concerns? ☐ Normal ☐ Picky ☐ Eats too much ☐ Weight loss/ gain

Oral-motor concerns? ☐ None ☐ Difficulty swallowing ☐ Drooling ☐ Gagging

Where does your child sleep? Own bedroom Bedroom parent(s) sleep in Shared bedroom with ____________

Does your child have problems falling asleep? Yes No

If a yes, how long does it take for him/her to fall asleep? __________ hours

Does your child wake up in the middle of the night? Yes No

If Yes, how many times per night typically? ______________________________
How long does it take for him/her to go back to sleep? ____________________
How many hours does your child currently sleep at night? ____________

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

Has your child been given a specific diagnosis?

☐ Learning disability
☐ Language disorder
☐ Attention Deficit Disorder (ADHD)
☐ Oppositional Defiant Disorder (ODD)
☐ Autism/ Asperger's/ PDD
☐ Other ______________________________
☐ Mental Retardation
☐ Developmental Delay
☐ Epilepsy
☐ Tourette's Disorder
☐ Fragile X
☐ Genetic Disorder ____
☐ Anxiety Disorder
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia

Surgeries: Age: ______ Reason: _________________________________Where: _________________________________
Other details ____

Hospitalizations: Age: ______ Reason: ___________________________Where: _________________________________
Other details ____

Major accidents or injuries: Age: _______ Type (head, abdomen, fracture, etc.) __________________________________
Other details ____

Has your child ever been unconscious? ☐ Yes ☐ No If yes, please explain: ________________________________
____

Does your child have current problems with:

	Yes	No	?		Yes	No	?
Ears (specify) ________________				**Appetite, digestion, stomach problems**			
Poor Hearing				Frequent stomach aches			
Chronic earaches/ infections				Poor eating habits			
Draining ears				Frequent vomiting			
				Soiling or daytime accidents			
Eyes (specify) ________________				Constipation			
Poor vision				Problems with weight			
Crossed eyes							
Wears glasses							
	Yes	**No**	**?**		**Yes**	**No**	**?**
Endocrine/ Gland				**Blood Disorder**			

Thyroid problems				Anemia			
Diabetes				Excessive bleeding or bruising			
Hypo/Hyperpituitarism				Leukemia			
Growth problems				Sickle cell disease			
Other: ________________________				Other__________________________			
Nervous system				**Urine or bladder** problems			
Frequent and/ or severe headaches				Bedwetting			
Seizures or convulsions				Daytime wetting or accidents			
Tremors or twitches				Urine infections			
Paper and pencil coordination problems				Other __________________________			
Balance or coordination problems							
Other _________________________				**Chest or Breathing**			
				Wheezing/ asthma			
				Other: ____________________________			

Has your child had any of the following?

Ear Tubes ☐ Yes ☐ No If yes, number of tube placements ____________________
Encephalitis ☐ Yes ☐ No
Meningitis ☐ Yes ☐ No
Poisoning or drug intoxication ☐ Yes ☐ No
Coma ☐ Yes ☐ No
Staring spells ☐ Yes ☐ No
Immune system disorders ☐ Yes ☐ No
Other significant illness ☐ Yes ☐ No

If yes to any of the above, please describe: ____
____

Has your child had any of the following tests or evaluations?

	Yes	Date (month/ year)	Where	Results
Neurologic Evaluation				☐ Normal ☐ Abnormal ☐ Don't Know
CT scan of head				☐ Normal ☐ Abnormal ☐ Don't Know
MRI scan of head				☐ Normal ☐ Abnormal ☐ Don't Know
EEG				☐ Normal ☐ Abnormal ☐ Don't Know
Audiology or hearing evaluation				☐ Normal ☐ Abnormal ☐ Don't Know
Vision evaluation				☐ Normal ☐ Abnormal ☐ Don't Know
Genetic Testing				☐ Normal ☐ Abnormal ☐ Don't Know
Other laboratory tests				☐ Normal ☐ Abnormal ☐ Don't Know

Family Medical History

Father: Health, learning, mental health problems? (please specify) ______________________________

____

Child's siblings: Health, learning, mental health problems? (please specify)______________________

____

Have any of the child's family members had the following problems/disorders? Please specify the family member's relationship to the child and whether the relationship is on the maternal (m) or paternal (p) side. Example: aunt (p) = aunt on the father's side.

	Family Member(s) Relation to Child		Family Member(s) Relation to Child
☐ Birth defect	____________	☐ Reading problem	____________
☐ Genetic disorder	____________	☐ Other learning disability	____________
☐ Cerebral palsy	____________	☐ Speech/ language delay	____________
☐ Severe head injury	____________	☐ Did not graduate from high school	____________
☐ Migraine headaches	____________	☐ Mental retardation	____________
☐ Multiple sclerosis	____________	☐ Autism/ Aspergers/ PDD	____________
☐ Physical handicap	____________	☐ ADHD	____________
☐ Tuberous sclerosis	____________	☐ Oppositional/ defiant behaviors	____________
☐ Huntington's chorea	____________	☐ Antisocial behavior	____________
☐ Muscular dystrophy	____________	☐Aggression	____________
☐ Sickle-cell anemia	____________	☐Tics/ Tourette's Disorder	____________
☐ Seizures or epilepsy	____________	☐ Nervousness/ anxiety	____________
☐ Cancer	____________	☐ Obsessive-Compulsive Disorder	____________
☐ Diabetes	____________	☐ Depression	____________
☐ Heart Disease	____________	☐ Bipolar/ manic depressive disorder	____________
☐ Alcohol/ Drug abuse	____________	☐ Schizophrenia	____________
☐ Physical/ sexual abuse	____________	☐ Other (specify)	____________

Have any maternal family members ever received extra help in school, early intervention, or special education services?
☐ Yes ☐ No

If yes, specify who and the reason ____

____

Personal/Social Information

What are your child's main hobbies and interests?

____

What about your child makes you most proud?

____

What does your child dislike doing most?

____

How many close friends does your child have? _______________

Does your child have a best friend? Yes No If yes, how old is he or she? _______________

How long have they been friends? ______ years ______ months

How easily does your child make friends? Worse than average Average Better than average

Does your child have problems keeping friends? Yes No

How well does your child get along with friends? Worse than average Average Better than average

If Below Average, please explain: ____

Does your child get along best with: Older children Children of the same age Younger children

Educational History

Has your child received Early Childhood Intervention services? Yes (Dates: __________) No

Did your child attend preschool? Yes No If yes, at what age? __________

Name of preschool: ____

Were there any adjustment problems in preschool? Yes No

Were you concerned about your child's ability to succeed in preschool? Yes No

Name of child's current school: ____

School district: ____

Address of school: ____

Telephone: _______________ Grade: _______ Teacher: ______________________________

Has your child ever been retained? Yes No What grade? _________Why?_____________________________

Is your child absent from school: Often Seldom Never

Usual reason for absence ____

If your child is in school please, comment on the areas below:	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance					
Reading					
Writing					
Mathematics					
Relationship with teachers					
Relationship with peers					
Participation in organized activities (e.g., teams)					

Has testing been completed by school? Yes No Date: ____

(Please attach a copy of the school evaluation)

Present class placement: Regular class Special class (if so, specify)______________________
Bilingual/ESL Gifted & Talented

Does your child have an IEP (Individualized Education Plan)? Yes No
Does your child have a 504 Plan? Yes No

If yes, for what reason? ____

(*Please attach a copy of the IEP/504 Plan*)

Special Education Categories: Please check all that apply (specify since what grade child has been in this placement):

- ☐ Autism Spectrum Disorder (ASD) Grade:_______________
- ☐ Communication Disorder Grade:_______________
- ☐ Deaf-blind Grade:_______________
- ☐ Developmental Delay Grade:_______________
- ☐ Emotional Disability (ED) Grade:_______________
- ☐ Hearing Impairment Grade:_______________
- ☐ Learning Disability (LD) Grade:_______________
- ☐ Mental Disability Grade:_______________
- ☐ Multiple Disabilities Grade:_______________
- ☐ Orthopedic Impairment Grade:_______________
- ☐ Other Health Impairment (OHI) Grade:_______________
- ☐ Traumatic Brain Injury Grade:_______________
- ☐ Visual Impairment Grade:_______________

Have any of the following instructional modifications been attempted?

Oral tests
Additional instructions
Manipulatives in math
Preferential seating
Peer teaching
Reduced paper and pencil work
Repeated review
Study carrel

Extended time to complete assignments
Shortened or modified assignments
Study Sheets
Control of distractions
Behavior modification program
Outlines
Positive reinforcers
Behavior check cards / charts
Predictable routines and classroom rules
Increased positive feedback
Technologic assistance (word processor, calculator, augmentative communication device, etc.)
Other ___________________________________

How successful have the above interventions been?____

Behavior and Discipline

Please describe briefly any behavioral problems at school: ____

____

Has your child ever been assigned:

Out of School Suspension	Number of suspensions _________
☐ In School Suspension	Number of suspensions _________
Expulsion	Number of expulsions _________

Please describe briefly any behavioral problems at home:

____

____

Types of discipline you use with your child:

Rewards
Time out (isolation)
Ignoring behavior
Giving in to child
Verbal reprimands / verbal demands
Removal of privileges
Physical punishment
Other (please specify) ______________________

Which form(s) of discipline has proven most effective? ____________________________________

____

Which form(s) of discipline has proven least effective? ____________________________________

____