

DEVELOPMENTAL HISTORY

Please complete both the front and back of this form. The information you provide will give us a better understanding of your child.
This information will become a part of your child's confidential school record.

Form Completed by: _____

Relationship to the child: _____

Date Completed: _____

FDLRS-CHILD FIND † ° Jacksonville, FL 3220 ...h= (904) 346-4601 ...FAX (904) 346-4611

1. FAMILY INFORMATION

Child's Legal Name: _____
First Middle Last

Address: _____
City State Zip

Place of Birth: _____ Date of Birth: _____ Age: _____ Gender: _____ Ethnicity: _____

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Mother's Home phone: _____ Work phone: _____

Cell Phone: _____ Email address: _____

Father's Home phone: _____ Work phone: _____

(if different) Cell Phone: _____ Email address: _____

In an emergency, contact: _____ **At this number:** _____

Does the child live with both parents? Yes No If No, who should be contacted? _____

Does this person have legal guardianship? Yes No _____

Names of others living in Adults: _____

the home Children: _____

(for children include age)

2. BIRTH/MEDICAL HISTORY

Child's birth weight: _____ Months carried: _____ Delivery Type: Caesarean Normal

Mother's health during pregnancy: _____

Birth complications: _____

Where does your child receive medical care? _____

Is your child taking any Yes No If Yes, please explain... _____

medications at this time? _____

Has your child had any of the following problems? Check all that apply.

- | | | | | |
|-----------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Physical Impairment | <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Avoids eye contact |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Clumsy | <input type="checkbox"/> Frequent tantrums | <input type="checkbox"/> Problems with toilet |
| <input type="checkbox"/> High Fevers | <input type="checkbox"/> Major Illnesses | <input type="checkbox"/> Overly active | <input type="checkbox"/> Eating difficulties | <input type="checkbox"/> Problems with peer |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Falls frequently | <input type="checkbox"/> Withdraws from | <input type="checkbox"/> relationships |

If so, please explain... _____

3. PRIMARY LANGUAGE SURVEY

Please list *all languages* spoken in the home? _____

Which of these languages does your child *understand best*? _____

Which of these languages does your child *use the most to talk*? _____

4. CHILD'S DEVELOPMENT

How do you view your child's development compared to other children the same age? _____

My main *concern(s)* for my child is/are _____

My child's *strengths* or things he/she likes are _____

My child's *weaknesses* or things he/she doesn't like are _____

Give the approximate age at which the child first did the following:

_____ Sat	_____ Crawled	_____ Walked
_____ Babbled	_____ Spoke in single words	_____ Spoke in sentences
_____ Self-Feeding	_____ Self-Dressing	_____ Toilet-Trained

Describe your child's communication in your own words: _____

What efforts have the family made to improve speech/language skills? _____

Please check all that apply.

- | My child... | My child... | My child is using words consistently and he/she... | |
|------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Points to named items | <input type="checkbox"/> Uses 50-100 words | <input type="checkbox"/> Is difficult for me to understand | <input type="checkbox"/> Stutters |
| <input type="checkbox"/> Follows 1-2 step directions | <input type="checkbox"/> Asks questions | <input type="checkbox"/> Is difficult for others to understand | <input type="checkbox"/> Avoids talking |
| <input type="checkbox"/> Responds to Y/N questions | <input type="checkbox"/> Uses 3-5 word phrases | <input type="checkbox"/> Changes/substitutes sounds | |
| <input type="checkbox"/> Responds to wh- questions | <input type="checkbox"/> Uses words to socialize | <input type="checkbox"/> Leaves out sounds/syllables/words | |

5. OTHER INFORMATION

Is your child currently enrolled in a Child Care Center/Preschool? Yes No If Yes, complete the following:

Center Name: _____

Contact Name: _____

Center Address: _____

Contact Number: _____

Does your child receive any of the following services? Check all that apply.

- | | | |
|-------------------------------------------------------|---------------------------|-------|
| <input type="checkbox"/> Speech-Language Therapy: | Name & number of provider | _____ |
| <input type="checkbox"/> Occupational Therapy: | Name & number of provider | _____ |
| <input type="checkbox"/> Physical Therapy: | Name & number of provider | _____ |
| <input type="checkbox"/> Early Intervention Services: | Name & number of provider | _____ |

Please list other agencies that *are now or have ever been involved* with your child:

If your child has a caseworker, please provide the following:

Name _____ Phone _____ Organization _____