Developmental History Form

Bennington Public Schools

Tara Mattson, School Psychologist

BENNINGTON PUBLIC SCHOOLS
Developmental History Form

Student's Legal Name: _____ DOB: _____
Person Completing Form:_____ Date:_____

Parent/Guardian(s) Information:
Mother: _____ Place of Employment: _____
Father:_____ Place of Employment: _____

Child Lives With: (circle all that apply): Both Parents Mother Father Stepmother Stepfather Guardian Siblings (how many)_____ Others- (please indicate name and relationship to student):

Please indicate names and ages of siblings:

List all schools attended (including preschool) and indicate for which grade levels:

Prior special education services? No___ Yes___ (If yes, please explain)

Family history of learning or emotional problems? No___ Yes___ (If yes, please explain)

Were there any problems with the pregnancy or birth of this child? No___ Yes___ (If yes, please explain)

Birth weight? ____lbs. ____oz. Length of pregnancy: _____ weeks

List any substances used during pregnancy (Alcohol, tobacco, prescription/ non-prescription drugs, etc.):

Age that this child met the following developmental milestones:

Rolling over: _____ Sitting Up: _____
Crawling: _____ Standing: _____
First steps: _____ First Word: _____

Did speech development progress normally? No ___ Yes ___ (if no, please explain)

Does your child have any vision or hearing problems? No___ Yes___ (If yes, please explain)

Has your child had a history of speech/communication problems and/or therapy? No____ Yes____ (If yes, please explain)

Has your child experienced any accidents requiring medical assistance? No____ Yes___ (If yes, please explain)

Has your child experienced any significant health problems (i.e., asthma, chronic ear infections, diabetes, seizures, etc.)? No___ Yes___ (If yes, please explain)

Has your child been hospitalized? No___ Yes___ (If yes, please explain)

Please circle if your child has had a history of any of the following:

Nightmares Trouble sleeping Cruelty to Animals Fire Setting
Anxiety Tantrums Disobedience Eating Disorder
Depression Mood Swings Suicide Threats/Attempts

Has your child received any psychological testing or counseling in the past? No___ Yes___ (If yes, please explain)

Does your child show signs of having attention problems? No___ Yes___
Does your child have an ADHD diagnosis by his/her medical provider? No___ Yes___
Have any family member(s) been diagnosed with an Attention Disorder? No____ Yes___ (Please indicate who: _____)

Is your child taking any medication on a regular basis? No___ Yes___ (If yes, please indicate name of medication and purpose for taking)

Has your child been prescribed any medication you have chosen not to administer? No___ Yes___ (If yes, please explain)

Have there been any changes in your family situation or traumatic events in the past – such as divorce, a move, death in the family, remarriage, absence of a parent from the home? No___ Yes___ (If yes, please explain event, approximate date)

List your child's strengths/talents:

Please explain any concerns that you have regarding your child:

Is there any other information that you think would be helpful for the Multidisciplinary Team to know? No ___ Yes ___ (if yes, please include that information here):

Thank you for completing this survey! Once completed, please return to either your child's teacher or the school office.