ASPIRE Center for Learning and Development

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

Person Completing Form:	Date:
Referred By:	
Child's Address	Phone:
E-mail:	
Child lives with: (e.g., both biological parents, single biological parent, foster parent[s], adoptive parent[s])	

Mother's Name:	DOB:
Mother's **Occupation**:	Enter appropriate # from box below:
Mother's **Education**:	Enter appropriate # from box below:
Father's Name:	DOB:
Father's **Occupation**:	Enter appropriate # from box below:
Father's **Education**:	Enter appropriate # from box below:

OCCUPATION

1. Clerical worker/technician
2. Unskilled employee
3. Executive or professional (physician, attorney)
4. Semi-skilled employee
5. Manager/professional (teacher, nurse, accountant)
6. Administrator/small business manager
7. Skilled manual employee
8. Other (specify):_____
9. Can't answer this question

HIGHEST LEVEL OF EDUCATION

1. Up to 6th grade
2. 7th, 8th, or 9th grade
3. 10th or 11th grade
4. 12th grade
5. Through sophomore year in college/2 yr. college
6. Through junior year in college
7. 4 year college
8. Graduate school (M.A./M.D/Ph.D./JD.)
9. Can't answer this question

(if parent has retired or is otherwise not working, specify parent's occupation prior to retirement)

Child's siblings (list brother and sisters):

Name	DOB	Developmental or Learning Problems (describe)

ASPIRE Center for Learning and Development

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

List your child's diagnoses and professionals (e.g., pediatrician, neurologist, psychiatrist, psychologist)

Diagnosis and Date	Professional making diagnosis

Describe your concerns and questions that you would like addressed:

Behavior:

Social:

Communication:

Cognitive / thinking skills:

Adaptive skills:

Academic / Educational:

Mental health (e.g., mood, anxiety):

Sleep:

Appetite:

Other:

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

DEVELOPMENTAL HISTORY

Perinatal History

How many pregnancies were there prior to the pregnancy with this child?_____ (times)

Please describe any problems that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.):

Current Pregnancy

1. Was this pregnancy full term? ☐ Yes ☐ No
   If not, how many weeks before or after the expected due date was delivery? _____ (weeks)
   BEFORE / AFTER *(circle one)*

2. Was this a multiple pregnancy? ☐ Yes ☐ No
   Were the babies identical? ☐ Yes ☐ No

3. List medical complications that occurred during this pregnancy (✓ all that apply):

Pre-existing diabetes	☐	High Blood Pressure	☐	Threatened miscarriage	☐
Gestational diabetes	☐	Swelling of hands/feet	☐	Severe nausea	☐
Thyroid disease	☐	Pre-eclampsia	☐	Poor weight gain	☐
Liver disease	☐	Eclampsia	☐	Rh Incompatibility	☐
Heart disease	☐	Toxemia	☐	Other (specify)_____	

4. List medications taken during this pregnancy:

5. Did mother consume more than 2 glasses of alcohol a day during this pregnancy? ☐ Yes ☐ No

Labor and Delivery

1. In what position was the baby born?
   Normal vertex position (head first) ☐ Breech (legs or bottom first) ☐ Cesarean section ☐
   Other (describe):_____

2. Note whether any problems occurred during labor or deliver (✓ all that apply):

Excessive bleeding	☐	Bag of water ruptured more than 1 day before delivery	☐
Meconium staining	☐	Umbilical cord around baby's neck	☐
Fever or infection of mother	☐	Breathing difficulties of child	☐
Placenta previa or abruption	☐	Other (specify)_____	

3. What was the child's birth weight? _____Pounds _____Ounces

4. Provide Apgar Scores, if known: _____ at 1 min _____ at 5 min

5. List problems that occurred during delivery (including medication taken):

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

Labor and Delivery (continued)

6. Was your child healthy as a newborn? ☐ Yes ☐ No
   If not, describe the problems and treatment:

7. Did your child have any congenital abnormalities at birth? ☐ Yes ☐ No
   If yes, specify:

8. Was there evidence of birth injury? ☐ Yes ☐ No
   Explain:

9. Did the baby require any special care immediately after birth? ☐ Yes ☐ No
   If Yes, ✓all of the following boxes **that apply**:

Breathing problems requiring oxygen	☐	Blood transfusions	☐
Breathing problems requiring mechanical ventilation (a tube in windpipe)	☐	Placement in an incubator	☐
Significant muscle weakness or paralysis	☐	Feeding difficulties	☐
Poor muscle tone	☐	Unresponsiveness	☐
Excessive sensitivity to noise/stimulation	☐	Jaundice treated with lights	☐

Surgery (specify):_____ ☐

Developmental Milestones

It may be helpful to review infant/toddler milestone books or past reports when completing the following questions. If you are uncertain, estimate as best as you can. Record the **ages** of acquisition in **months**.

Smiled in response to others	_____months	Bladder control (**daytime**)	_____months
Sat without support	_____months	Stood alone	_____months
Crawled	_____months	Walked independently	_____months
Bladder (**nighttime**)	_____months	Bowel control	_____months

Spoke using meaningful words (other than mama/dada) _____months

Spoke in 3-word phrases _____months Spoke in full sentences (at least 4 words)_____months

At what age did you first notice problems (developmental delays or differences) in:

Social development _____months

Speech and language _____months

Problem solving _____months

Behavior _____months

In hindsight, at what age (in months) did your child first show any developmental problems or difficulties? _____months
Specific concerns:

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

Developmental Milestones (continued)

Did your child experience a significant loss of an acquired skill or skills? If so, indicate:

Social functioning ☐ explain:_____

Speech/language ☐ explain:_____

Problem solving ☐ explain:_____

Motor coordination ☐ explain:_____

Bladder/bowel ☐ explain:_____

Describe the problems (if any) that your child has experienced with regard to speech, language and nonverbal communication:

_____

_____

How verbal is your child?

overly talkative ☐ normally verbal ☐ somewhat verbal ☐ nonverbal ☐

How frequently does your child use communicative gestures (e.g., waving, head nodding/shaking, beckoning)?

very frequently ☐ relatively often ☐ occasionally ☐ rarely ☐ never ☐

✓ the following boxes that indicate how your child lets you know what he/she wants or needs?

Tells you ☐

Pull you without eye contact or speech ☐

Points/gestures without reciprocal (back/forth) eye contact ☐

Cries or scream only ☐

Points/gestures with reciprocal (back/forth) eye contact ☐

Pulls you with reciprocal eye contact and/or appropriate speech ☐

Other (explain):_____

✓ the following boxes for which your child communicates (verbally and nonverbally):

To make requests ☐

To inquire about the interests, ideas and thoughts of others ☐

To indicate preferences ☐

To share concrete observations ☐

To chat socially ☐

To share interests, ideas and thoughts ☐

To demonstrate empathy and caring ☐

Other (explain):_____

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

Developmental Milestones (continued)

Does your child have speech articulation difficulties? ☐ Yes ☐ No
If Yes, explain: _____

How well is your child understood by parent/siblings? well ☐ adequately ☐ with effort ☐ poorly ☐

How well is your child understood by relatives/friends? well ☐ adequately ☐ with effort ☐ poorly ☐

How well is your child understood by unfamiliar people? well ☐ adequately ☐ with effort ☐ poorly ☐

Is your child's speech unusual? ☐ Yes ☐ No
If Yes, ✓ all boxes that apply:

- High or low pitched intonation ☐
- Irregular speech rhythm (cadence) ☐
- Unusual intonation (e.g., sign-son pattern, question-like melody) ☐
- Overly formal or pedantic ☐
- Reduced intonation (monotone speech) ☐
- Other (specify):_____

✓ the following boxes that indicate unusual language forms used by your child:

- None ☐
- Repetitive/perseverative phrases ☐
- Echoed speech (immediately after word/phrase heard) ☐
- Idiosyncratic/personalized (made-up) words ☐
- Echoed speech (days/weeks after heard) ☐
- Or phrases (used consistently) ☐

MEDICAL HISTORY

I have confirmed with my child's Primary Care MD that his/her immunizations are up-to-date. ☐ Yes ☐ No
If No, explain

List below serious injuries (and treatment) sustained by your child (e.g., head injuries, loss of consciousness):

Date or Age	Injury	Treatment (e.g., hospitalization, surgery)/Outcome

Describe serious illnesses and medical conditions, including the treatment received

Nervous System Problems (such as seizures, meningitis, encephalitis, hypotonia, congenital abnormalities, stroke)

Date or Age	Injury	Treatment and Outcome

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

Nervous System Problems (continued)
If your child has had any specialized tests of his/her nervous system, complete the following:

✓ all that apply	Test		Result
☐date:	EEG (brain wave test)	☐	
☐date:	CT Scan	☐	
☐date:	MRI Scan	☐	
☐date:	PET/SPECT/MRI Spectroscopy	☐	

Vision Problems (such as lazy eye, nearsighted or farsighted vision, retinal problems, cataracts, blindness, etc.)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Ear/Hearing Problems (such as recurrent ear infections, ear tubes, hearing loss, deafness, etc.)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Has your child ever had a hearing test? ☐ Yes ☐ No
If Yes, describe the result:

Dental Problems (such as delayed tooth eruption, abnormally shaped or missing teeth, extractions, braces, cavities)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Endocrine Problems (problems with thyroid, calcium, or "sugar" diabetes: early, late or incomplete puberty)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Growth Problems (failure to gain weight, weight gain, short stature, tall stature, etc.)

Age of Onset	Nature, Duration Pattern of Problem	Treatment and Outcome

Heart Problems (congenital heart disease, heart murmur, blood vessel disease, heart surgery, high blood pressure)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

ASPIRE Center for Learning and Development

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

Respiratory Problems (asthma, pneumonia, apnea, irregular breathing)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Gastrointestinal Problems (swallowing, gastroesphageal reflux, abdominal pain, diarrhea, constimpation, irritable bowel, etc.)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Kidney Problems (kidney or bladder infections, urinary frequency, congenital abnormalities, obstructions, etc.)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Muscle, Bone and Joint Problems (congenital abnormalities, spinal curvature, joint laxity or tightness)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Skin Problems (eczema, psoriasis, dry skin, skin picking, etc.)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

Genetic Syndromes or Conditions (Down, fragile X, Williams, Prader Willi syndromes, tuberous sclerosis, etc.)

Date or Age	Nature of Illness/Condition	Treatment and Outcome

If your child has had any specialized **genetic testing** complete the following:

✓ all that apply	Test	Result
☐date:	Chromosomal Analysis (cytogenetics)	
☐date:	Molecular Testing for fragile X syndrome (e.g., PRC)	
☐date:	Molecular Testing for Williams Syndrome	
☐date:	Molecular Testing for Prader Willi Syndrome	
☐date:	Other (specify):	

ASPIRE Center for Learning and Development

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

Hospitalizations and Surgery (record hospitalization and surgery below)

Date/Age	Reason for Hospitalization/Surgery	Name of Hospital	Treatment and Outcome

Medications (record all medications prescribed for behavioral, affective, and emotional difficulties and responses)

Medication	Dates Administered		Reasons for Prescription	Response to Medication (positive and negative)
	From	To		

Allergies (to medications, foods, environmental antigens, etc.)

Source of Reaction (medication, food, etc.)	Nature of Reaction (clinical signs and symptoms, e.g., hives, trouble breathing, etc.)

ASPIRE Center for Learning and Development

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

Specialty Evaluations (list the specialists who have evaluated your child)

Specialist	Date	Reason for Assessment and Results
Developmental Pediatrician		
Neurologist		
Psychiatrist		
Geneticist		
Psychologist		
Speech/Language Specialist		
Occupational Therapist		
Physical Therapist		
Other (specify):		

FAMILY HISTORY

Indicate if child and/or family members have experienced the following conditions:
Smoking ☐ Alcohol Abuse ☐ Drug Abuse ☐

Nuclear Family	Autism	Asperger Syndrome	PPD	Mental Retardation	Learning Disability	Language Disorder	Genetic Condition (e.g., fragile X)	Social Problems	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	☐	
Sister(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Brother(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Extended Family Maternal Relatives									
Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	
Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	
Aunt(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Uncle(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Cousin(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Extended Family Paternal Relatives									
Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	
Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	
Aunt(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Uncle(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Cousin(s)	☐	☐	☐	☐	☐	☐	☐	☐	

ASPIRE Center for Learning and Development

Child's Name:	DOB:	Age:	Sex: ☐M ☐F

EDUCATIONAL HISTORY

Child's current grade:
Child's current school:_____ District:_____

✓ *the box that describes the type of educational program in which your child is currently enrolled:*

- Full time in a regular class ☐
- Regular class supplemented by resource room/learning lab time ☐
- Time split between regular and special education classes ☐
- Special education class in a neighborhood school ☐
- Specialized school ☐
- Home schooled ☐

✓ *the box that your child has a:*

- Full time aide/paraprofessional ☐
- Part time aide/paraprofessional ☐
- Shared aide/paraprofessional ☐
- No paraprofessional support ☐

Indicate the educational program in which your child participated during his/her school years:

School Year	Type of School		Type of Class		Any Special Services		
	Regular*	Special*	Regular*	Special*	Yes	No	Type
Pre-K	☐	☐	☐	☐	◯	◯	
Kindergarten	☐	☐	☐	☐	◯	◯	
1st	☐	☐	☐	☐	◯	◯	
2nd	☐	☐	☐	☐	◯	◯	
3rd	☐	☐	☐	☐	◯	◯	
4th	☐	☐	☐	☐	◯	◯	
5th	☐	☐	☐	☐	◯	◯	
6th	☐	☐	☐	☐	◯	◯	
7th	☐	☐	☐	☐	◯	◯	
8th	☐	☐	☐	☐	◯	◯	
9th	☐	☐	☐	☐	◯	◯	
10th	☐	☐	☐	☐	◯	◯	
11th	☐	☐	☐	☐	◯	◯	
12th	☐	☐	☐	☐	◯	◯	

***REGULAR school applies to public or private schools for children without disabilities**
***SPECIAL school applies to any school(s) intended for children with disabilities.**

College attendance: ☐ Yes ☐ No Number of years completed:_____yrs Degree:_____

Signature of Person Completing Form:	Date Form Completed:
Print Name of Person Completing Form:	
Relationship to Child	

Reviewed By (Clinician's Signature):	Date Reviewed: