ASPIRE Center for Learning and Development
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

Person Completing Form:	Date:
Referred By:	
Address	Phone #:
E-mail:	

Currently living with: (e.g., both biological parents, single biological parent, foster parent[s], adoptive parent[s], roommate, spouse, independently, etc.)

Your Occupation: Enter appropriate # from box below:

Your 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

Siblings (list brother and sisters):

Name	DOB	Psychological, Developmental or Learning Problems (describe)

ASPIRE Center for Learning and Development
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

List any current diagnoses and professionals (e.g., pediatrician, neurologist, psychiatrist, psychologist)

Diagnosis	Professional making diagnosis	When diagnosis received

Please describe your concerns and questions that you would like the Assessment Team to address:

ASPIRE Center for Learning and Development
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

DEVELOPMENTAL HISTORY

(Please provide as much information as you can to the following questions – we realize that you may not have answers to many of the questions)

Perinatal History

How many pregnancies were there prior to your mother's pregnancy with you?_____ (times)

Describe any problems you are aware of that occurred during previous pregnancies (e.g., miscarriage, premature labor and delivery, etc.):

Current Pregnancy (with you)

1. Was the pregnancy with you 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 (Twin ☐ Triplet ☐ Quadruplet ☐)
   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 mother took during this pregnancy:

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

ASPIRE Center for Learning and Development
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

Labor and Delivery

1. In what position were you 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 your birth weight? _____Pounds _____Ounces

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

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

Labor and Delivery (continued)

6. Were you healthy as a newborn? ☐ Yes ☐ No
   If not, describe the problems and treatment:

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

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

9. Did you 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):_____	☐		

ASPIRE Center for Learning and Development
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

Developmental Milestones

It may be helpful to review this section with parents and/or 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 or your parents 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 you first show any developmental problems or difficulties? _____months
Specific concerns:

Name:	DOB:	Age:	Sex: ☐M ☐F

Developmental Milestones (continued)

Did you 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 you have experienced with regard to speech, language and nonverbal communication:

How verbal are?

overly talkative ☐ normally verbal ☐ somewhat verbal ☐ nonverbal ☐

How frequently do you use communicative gestures (e.g., waving, head nodding/shaking, beckoning)?

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

✓ the following boxes for which you communicate (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):_____

Name:	DOB:	Age:	Sex: ☐M ☐F

Developmental Milestones (continued)

Do you have speech articulation difficulties? ☐ Yes ☐ No
If Yes, explain:

How well are you understood by parent/siblings? well ☐ adequately ☐ with effort ☐ poorly ☐

How well are you understood by relatives/friends? well ☐ adequately ☐ with effort ☐ poorly ☐

How well are you understood by unfamiliar people? well ☐ adequately ☐ with effort ☐ poorly ☐

Is your 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 you use:

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

List below serious injuries (and treatment) sustained by you (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

Name:	DOB:	Age:	Sex: ☐M ☐F

Nervous System Problems (continued)
If you 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

Have you 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
DEVELOPMENTAL and MEDICAL HISTORY

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 you 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	

ASPIRE Center for Learning and Development
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

☐date:	Other (specify):	

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
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

Specialty Evaluations (list the specialists who have evaluated you)

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 you 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									

ASPIRE Center for Learning and Development
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

Aunt(s)									
Uncle(s)									
Cousin(s)									

EDUCATIONAL HISTORY

✓ the box that describes the level of education that you have attained::

Elementary and Middle School ☐

Some High School ☐

High School (GED, Diploma, etc.) ☐

College ☐ Did you graduate? ☐ Yes ☐ No Degree:_____

Graduate ☐ Did you graduate? ☐ Yes ☐ No Degree:_____

Ph.D. or other ☐ Degree/Certificate:_____

Are you currently in school, if so where and what type?

Yes, I am currently in school ☐ No, I am currently not in school ☐

If answered Yes, where do you go to school? _____

Indicate the educational program in which you participated during your 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							

Name:	DOB:	Age:	Sex: ☐M ☐F

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.**

EMPLOYMENT HISTORY

Yes, I am currently working ☐ No, I am not currently working ☐ I volunteer ☐

If Yes, where are you working/volunteering? (Name of job, title, list of job responsibilities):

Yes, I currently have a job coach ☐ No, I do not have a job coach ☐

If Yes, what agency is your job coach from and what are you working on in job training:

If No, did have you had a job coach in the past? If you did, what agency was your job coach from and what did you work on together:

In space below, explain your work and job training history:

Signature of Person Completing Form:	Date Form Completed:

ASPIRE Center for Learning and Development
DEVELOPMENTAL and MEDICAL HISTORY

Name:	DOB:	Age:	Sex: ☐M ☐F

Print Name of Person Completing Form:	
Relationship to Adult:	
Reviewed By (Clinician's Signature):	Date Reviewed:

Thank you for taking the time to complete our paperwork!