Vandalia-Butler City Schools
306 South Dixie Drive, Vandalia OH 45377
937-415-6400

DEVELOPMENTAL HISTORY FORM

Please answer the questions on this form as well as you can. The questionnaire is confidential and your responses will be shared only with professional personnel.

I. GENERAL INFORMATION

Child's Name__________________ Sex___ DOB__________
Child lives with__________________ Relationship__________
Address______________________________
Home/Cell Ph.______________ Work Ph.______________
Occupation: (Father's)______________________
(Mother's)______________________
Family includes:

Brothers: Name	Age	Sisters: Name	Age
______	/ ____	______	/ ____
______	/ ____	______	/ ____
______	/ ____	______	/ ____

II. GENERAL HEALTH HISTORY

Family Doctor__________________ Phone__________
Family Dentist__________________ Phone__________
Please check any health concern:

___ Eczema
___ Sinus trouble
___ Concussion
___ Seizures
___ Serious blows to head
___ Headaches
___ Asthma
___ Heart related problems
___ Indigestion
___ Vomiting
___ Constipation
___ Diarrhea
___ Diabetes
___ Bed Wetting
___ Nightmares
___ Allergies (list)

Other physical/medical problems (explain):______________________

Is your child presently on medication?_____ What?______________
Has your child had any injuries or been hospitalized?____________

III. HEARING ASSESSMENT

Has this child ever had an ear/hearing examination/treatment? Yes____ No____
When?__________ By Whom?______________
Results:______________________________

	YES	NO
A. Has your child ever had ear tubes?	___	___
B. Does your child have tubes now?	___	___
C. Does your child:		
1. Have frequent earaches?	___	___
2. Seem to have difficulty hearing?	___	___
3. Turn on the TV louder than other members of the family?	___	___
4. Seem to favor one ear over the other?	___	___
5. Jump or appear to be more startled than others if there is a sudden noise?	___	___
6. Seem to hear you if you talk in a whisper?	___	___
7. Make you talk loudly or repeat frequently?	___	___
8. Become confused in following more than two verbal directions at a time?	___	___
9. Have difficulty remembering things for a long time?	___	___
10. Have difficulty remembering things for a short time?	___	___

D. Would you describe the noise/activity level in your home as:
___quiet ___moderately quiet ___moderately loud ___loud

IV. VISUAL ASSESSMENT

Has your child ever had a vision examination/treatment? ___ ___
When?__________ By Whom?______________
Results:______________________________

A. Do you suspect any vision problems?		
1. Seem to have difficulty seeing small lines or pictures?	___	___
2. Seem to have trouble seeing things far away?	___	___
3. Squint?	___	___
4. Wear glasses?	___	___
5. Have eyes that turn in?	___	___
6. Have eyes that turn out?	___	___
7. Sit very close to the television?	___	___
8. Rub eyes a lot?	___	___
9. Turn head as to use primarily one eye?	___	___
10. Lower one side of the head when looking at others?	___	___
11. Have eye infections?	___	___

V. PREGNANCY AND BIRTH HISTORY

	YES	NO
Did you have an illness or accident during pregnancy? If yes, please describe:	___	___
Did the baby come on time?	___	___
Were there any problems with delivery? If yes, please describe: (Caesarian, etc.)	___	___
Did your baby have any trouble starting to breathe? If yes, please describe:	___	___

If no, was the baby early? (how much) __________

If no, was the baby late? (how much) __________

What was the birth weight?__________ length?__________

List any medical problems your child experienced immediately after birth:

____

____

____

VI. LANGUAGE DEVELOPMENT

At what age did your child begin to speak? (Give approximate age if you do not remember exact age):

First words_______ Two or three words together_______ Sentence_______

Does your child:	YES	NO
1. Stutter?	___	___
2. Have trouble expressing ideas and concepts?	___	___

VII. MOTOR DEVELOPMENT

My child began walking at the age of:__________.

VIII. SOCIAL DEVELOPMENT

Does your child:	YES	NO
1. Separate from you easily?	___	___
2. Have regular playmates the same age?	___	___
3. Prefer to play with other children instead of alone?	___	___
4. Become easily frustrated?	___	___
5. Cry often?	___	___
6. Have a bad temper?	___	___
7. Become frequently irritated or moody?	___	___
8. Become upset at changes in routine?	___	___
9. Demand much individual attention?	___	___

IX. ADDITIONAL INFORMATION

	YES	NO
Has your child attended a preschool?	___	___

If yes, please indicate number of years:______.

Name of Preschool(s)
and Location: (1.)______________________________

____

____

(2.)______________________________

____

____

Is there any other information that will help us understand your child?______

____

____

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Would you like an individual conference with the staff to relate any information you don't feel you can include on this form? ___Yes ___ No