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Developmental History and Intake Screening Form

Date Form Completed: _____ **Person Completing the Form**: _____
Name and relationship to learner

Learner's Name: _____ **Sex**: M / F **Date of Birth**: _____

Address: _____
Street City State Zip

Phone Number: _____ **Email Address**: _____

REASONS FOR REFERREL

Please list the reason(s) the learner is being referred:

1. _____
   _____
2. _____
   _____
3. _____
   _____

When did these problems begin?

What are you goals for this referral?

Has the learner ever received the diagnosis of an autism spectrum disorder? ☐ Yes ☐ No
If yes, in what month & year _____ and by whom _____

Has the learner ever received the diagnosis of any related diagnosis? ☐ Yes ☐ No
If yes, in what month & year _____ and by whom _____

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FAMILY INFORMATION

Mother/Guardian Name: _____ Education: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Father/Guardian Name: _____ Education: _____

Occupation: _____ ☐ Full-time ☐ Part-time

Parents are:
- ☐ Married
- ☐ Unmarried, Living Together
- ☐ Never Married, Living Together
- ☐ Separated
- ☐ Divorced
- ☐ Mother Deceased
- ☐ Father Deceased

Child lives with:
- ☐ Biological Mother
- ☐ Biological Father
- ☐ Step-parent
- ☐ Adoptive Parent (specify) _____
- ☐ Grandparent
- ☐ Legal Guardian (specify) _____
- ☐ Other (specify) _____

Sibling Information

Name of sibling	Sex	Age	Different Father?	Different Mother?	List any health/behavior/ learning problems	Lives with child?
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N
			☐Y ☐N	☐Y ☐N		☐Y ☐N

How well does your child get along with his/her siblings?
☐ Very Well ☐ Good ☐ Average ☐ Fair ☐ Poor

Is English the learner's primary speaking language: ☐ Yes ☐ No

If no, what is the learner's primary language: _____

What is the learner's secondary language: _____

Child Care and Discipline

Who is primarily responsible for the learner's care? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Who is mainly in charge of discipline in the home? ☐ Mother ☐ Father ☐ Both ☐ Other:_____

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Please describe discipline techniques: _____

_____

FAMILY PSYCHIATRIC HISTORY

CONDITION/DISORDER	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENT	AUNT/ UNCLE	OTHER CLOSE RELATIVES
Alcoholism							
Anxiety							
ADHD/ADD							
Autism Spectrum Disorder							
Bipolar Disorder							
Depression							
Epilepsy/Seizure Disorder							
Genetic Condition							
Hospitalized for Emotional Problems							
Intellectual disability							
Jail Time/Incarceration							
Language disorder							
Learning Disability							
Motor or Vocal Tics							
Psychosis or Schizophrenia							
Special Education							
Substance Abuse							
Suicidal Ideation/Attempt							

PREGNANCY AND BIRTH HISTORY

Parental ages when learner was born: Mom _____ Dad _____

Was this pregnancy full term? ☐ Yes ☐ No If not, how many weeks before or after the expected due date was the baby born? _____ weeks ☐ Before ☐ After due date

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Pregnancy number: 1st, 2nd, 3rd, 4th, other ____ Totals: # of pregnancies _____ # of miscarriages _____

Was this a multiple birth? ☐ Yes ☐ No ☐ UK ; if yes: ☐ Twins ☐ Triplets ☐ Quadruplets

Were the babies identical? ☐ Yes ☐ No ☐ UK (unknown)

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

Mother's health during pregnancy:

☐ No health problems during pregnancy
☐ Poor weight gain
☐ Seizures
☐ High blood pressure
☐ Other (specify)_____
☐ Health during pregnancy not known
☐ Severe nausea {☐ with dehydration}
☐ Infections (Flu, measles, CMV)
☐ Eclampsia/Toxemia
☐ Rh (blood group) incompatibility

List medications taken during this pregnancy: _____

_____

_____

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

Did the mother smoke during pregnancy? ☐ Yes ☐ No

Did the mother consume illegal substances during the pregnancy? ☐ Yes ☐ No

Labor and Delivery:

☐ No problems during labor and delivery ☐ Not known

Please note whether any problems occurred during labor or delivery (☐ all that apply):

Baby was born ☐ head first ☐ breech (feet first) ☐ vaginal ☐ Cesarean (Why? _____

Birth weight _____ lbs _____ oz Length _____ in.

Newborn period:

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

_____

_____

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Was the child born with any birth defects? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Did the child require treatment in a newborn intensive care unit? ☐ Yes (for _____ days) ☐ No

Did the baby require any special care immediately after birth? ☐ Yes ☐ No

If yes, √ all that apply

☐ Breathing problems (requiring ☐ oxygen ☐ ventilator (with a tube in windpipe)
☐ Placement in an incubator
☐ Blood transfusions
☐ Significant muscle weakness or paralysis
☐ Poor muscle tone
☐ Seizures
☐ Feeding difficulties
☐ Excessive sensitivity to noise/stimulation
☐ Jaundice treated with lights
☐ Infection
☐ Surgery (describe): _____

DEVELOPMENTAL HISTORY

Social Development

Did you notice any delays in the learner's social development? ☐ Yes ☐ No

As an infant, did the learner:
Enjoying cuddling? ☐ Yes ☐ No _____

Tend to be fussy/irritable? ☐ Yes ☐ No _____

Make appropriate eye contact? ☐ Yes ☐ No _____

Respond to his/her name? ☐ Yes ☐ No _____

In the first four years of life, were any special problems noted in the following areas?
If yes, please describe below:

Temper Tantrums ☐ Yes ☐ No _____

Separating from parents ☐ Yes ☐ No _____

Excessive crying ☐ Yes ☐ No _____

Playing with other children ☐ Yes ☐ No _____

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Speech and Language Development

Did you notice any delays in the learner's language development? ☐ Yes ☐ No
If yes, please specify: _____

Did the following milestones develop on time? Please specify age (year/month).

Show interest in sound (by 3 months) ☐ Yes ☐ No _____

Babbling (by 4 to 6 months) ☐ Yes ☐ No _____

Understanding words (by 6-11 months) ☐ Yes ☐ No _____

Speaking first words (by 12 months) ☐ Yes ☐ No _____

Speaking in short phrases (by 24 months) ☐ Yes ☐ No _____

Motor Development

Did you notice any delays in the learner's motor development? ☐ Yes ☐ No
If yes, please specify: _____

Did the following milestones develop on time? Please specify age (year/month).

Turn over (by 6 months) ☐ Yes ☐ No _____

Sit alone (by 9-12 months) ☐ Yes ☐ No _____

Crawl (by 9-12months) ☐ Yes ☐ No _____

Stand alone (by 9-12 months) ☐ Yes ☐ No _____

Walk alone (by 12-18 months) ☐ Yes ☐ No _____

Walk upstairs (by 36 months) ☐ Yes ☐ No _____

Walk downstairs (by 48 months) ☐ Yes ☐ No _____

Running ☐ Yes ☐ No _____

Which hand does the learner use for writing or drawing? ☐ Right ☐ Left ☐ Both
Eating? ☐ Right ☐ Left ☐ Both
Throwing? ☐ Right ☐ Left ☐ Both

Daily Living

Is the learner toilet trained? ☐ Yes ☐ No _____

When was the learner toilet trained? Days: _____ Nights: _____

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Did bed-wetting occur after toilet training? ☐ Yes ☐ No If yes, until what age? _____

Did bed-soiling occur after toilet training? ☐ Yes ☐ No If yes, until what age? _____

Sensory Responding

Does the learner have difficulty with the following. If yes, please describe below:

Tolerating Food Textures ☐ Yes ☐ No _____

Gagging or Vomiting ☐ Yes ☐ No _____

Tolerating Clothing ☐ Yes ☐ No _____

Tolerating Touch from Others ☐ Yes ☐ No _____

Does Not Notice Pain ☐ Yes ☐ No _____

Tolerating Certain Sounds ☐ Yes ☐ No _____

Other _____

Significant LOSS of an acquired skill or skills (not just a delay)? For example, a child who was engaging in pretend play with other children for at least 4 to 6 months and then stopped and began just spinning, dropping, or throwing objects in his/her free time or speaking in full sentences for many months and then just stopped speaking altogether or began using only single words occasionally)

Social functioning ☐ Age of loss: _____ months; Explain: _____

_____

Speech / language ☐ Age of loss: _____ months; Explain: _____

_____

Problem solving ☐ Age of loss: _____ months; Explain: _____

_____

Motor coordination ☐ Age of loss: _____ months; Explain: _____

_____

Bladder/bowel control ☐ Age of loss: _____ months; Explain: _____

_____

MEDICAL HISTORY

☐ No serious illnesses or injuries in the past ☐ No serious illnesses or injuries now

Date	Age	Diagnosis/Illness	Past	Now	Date	Age	Diagnosis/Illness	Past	Now
		Serious Injuries	☐	☐			Lung/breathing Problems	☐	☐

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		Serious head injury	☐	☐			Asthma	☐	☐
		Other serious injury	☐	☐			Pneumonia	☐	☐
		Loss of consciousness	☐	☐			Apnea or irregular breathing	☐	☐
		Sleep Problems	☐	☐			Other: _____	☐	☐
		Neurological Problems	☐	☐			Stomach/bowel Problems	☐	☐
		Birth abnormality	☐	☐			Swallowing problems	☐	☐
		Seizures (any type)	☐	☐			Gastroesphageal reflux	☐	☐
		Other: _____					Chronic abdominal pain	☐	☐
		Vision Problem	☐	☐			Chronic diarrhea	☐	☐
		Vision problems at birth	☐	☐			Chronic constipation	☐	☐
		Requires glasses/contacts	☐	☐			Other: _____	☐	☐
		Other: _____	☐	☐			Kidney/Bladder Problems	☐	☐
		Hearing Problem	☐	☐			Abnormalities at birth	☐	☐
		Hearing problems at birth	☐	☐			Kidney/bladder infections	☐	☐
		Deafness	☐	☐			Other: _____	☐	☐
		Chronic ear infections	☐	☐			Muscle/bone/joint) Problems		
		Ear tubes	☐	☐			Abnormalities at birth	☐	☐
		Other: _____	☐	☐			Scoliosis or spinal curvature	☐	☐
Date	Age	Diagnosis/Illness	Past	Now	Date	Age	Diagnosis/Illness	Past	Now
		Dental Problem	☐	☐			Circulatory Problem	☐	☐
		Abnormally shaped/ missing teeth	☐	☐			Anemia	☐	☐
		Extractions/cavities	☐	☐			Sickle cell disease	☐	☐
		Dental braces	☐	☐			Chronic low platelet count	☐	☐
		Other: _____	☐	☐			Bleeding /bruising problem	☐	☐
		Skin Problem	☐	☐			Other: _____	☐	☐
		Eczema	☐	☐			Hormone Problem	☐	☐
		Ash leaf patches	☐	☐			Sugar diabetes	☐	☐
		Café-au-lait spots	☐	☐			Early puberty	☐	☐
		Other: _____	☐	☐			Late or incomplete puberty	☐	☐

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		Growth Problem	☐	☐			Other: _____	☐	☐
		Failure to gain weight	☐	☐			Mental Health problem	☐	☐
		Obesity	☐	☐			ADHD	☐	☐
		Short stature	☐	☐			Oppositional defiant disorder	☐	☐
		Tall stature	☐	☐			Anxiety disorder	☐	☐
		Other: _____	☐	☐			Obsessive-compulsive disorder	☐	☐
		Heart Problem	☐	☐			Depression	☐	☐
		Heart abnormalities at birth	☐	☐			Bipolar disorder (manic-depressive)	☐	☐
		Heart surgery	☐	☐			Schizophrenia	☐	☐
		Heart rhythm abnormalities	☐	☐			Tic disorder (e.g., Tourette)	☐	☐
		High blood pressure	☐	☐			Intellectual disability	☐	☐
		Other: _____	☐	☐			Eating disorder (e.g., anorexia)	☐	☐
							Other: _____	☐	☐

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

Specialized neurological or genetic tests:

☐ No neurological or genetic testing has been done

☐ If done	Date (if known) Month/Year	Test	Normal Result	Abnormal Result	Unknown Result
☐			☐	☐	☐
☐			☐	☐	☐
☐			☐	☐	☐
☐		rescopy	☐	☐	☐
☐			☐	☐	☐

List all hospitalizations and surgeries for the Learner, include overnight stays (medical or behavioral)

☐ No past hospitalizations or surgery

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Reason for hospitalization/surgery	Age	Length of stay

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

☐ No past or current allergies

Source (medication, food, etc.)	Nature of reaction (hives, trouble breathing, etc.)

Current Medications

☐ No medications taken now ☐ Medications are being taken now, but the names are not known

Medication	Dosage	Age at start	Reason for medication	Improved	
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N

Name of person prescribing the medications: _____

Dietary Restrictions/Supplements

☐ No Dietary restrictions/supplements now known ☐ Supplements are being taken now, but the names are not known

Supplement/Restriction	Dosage	Age at start	Reason for Supplement/Restriction	Improved	
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N
				☐Y	☐N

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RESOURCES: Please indicate resources/services being received outside of school now

☐ No resources/services are being received now outside of school
☐ Early Intervention Services ☐ Speech/Language therapy ☐ Psychiatry services
☐ Behavioral Consultation ☐ Group therapy ☐ Physical therapy
☐ Family therapy ☐ Applied Behavior Analysis ☐ Occupational therapy
☐ Other: _____
List names of agencies and specialists: _____

_____

_____

EDUCATIONAL HISTORY

School name: _____ Phone:_____
Grade in school: _____ (ever repeat a grade? Yes / No) Teacher (or best contact): _____

Is the Learner currently on a formal education plan in school? ☐ Yes ☐ No

If yes, please check: □ IEP □ 504 Plan

What best describes the Learner's current educational program?
Full time in a regular class ☐
Time split between regular and special education classes ☐
Special education class ☐
Aide/Paraprofessional or extra help ☐
Specialized school ☐
Home schooled ☐

Please indicate the educational program in which the Learner participated during his/her school* years:

School Year	Type of School		Type of Class		Any Special Services		
	Regular*/Class Special/ size		Regular*/Class Special*/ size		Yes	No	Type
3-5 preschool							
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 schools intended for children with disabilities

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Social Skills

Peer Relationships
Please indicate how the learner relates to peers:

- ☐ Has problems relating to other children
- ☐ Has difficulty making friends
- ☐ Fights frequently with peers
- ☐ Prefers playing with younger children
- ☐ Prefers playing with older children
- ☐ Prefers to play alone
- ☐ Has a best friend

What role does the learner take in peer groups? ☐ Leader ☐ Follower ☐ Some of Each

How many friends does the learner have? _____

Behavior Skills

Does the learner have. If yes, please describe below:

Difficulty with transitions ☐ Yes ☐ No _____

Difficulty with relinquishing items ☐ Yes ☐ No _____

Difficulty with Parent/s leaving ☐ Yes ☐ No _____

Demonstrate aggressive behavior/s ☐ Yes ☐ No _____

Engage in hitting/biting/kicking/
pinching/and/or punching ☐ Yes ☐ No _____

Engage in behaviors that cause harm
to self ☐ Yes ☐ No _____

Engage in behaviors that cause harm
to others ☐ Yes ☐ No _____

Demonstrate compulsive behaviors ☐ Yes ☐ No _____

Need things to be in a particular way/
routine/or repetition ☐ Yes ☐ No _____

Recreational Interests
What does the learner enjoy?

☐ Sports _____

☐ Hobbies_____

☐ Other _____

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What are the learner's personal strengths?

What do you enjoy most about the learner?

What are your hopes for the learner's future?

How did you hear about 121 Learning Works?

What types of services are you interested in?

When are you looking to start services, what environment/location, and at what frequency?

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