Selman Behavior Solutions

Finding Solutions ⋆ Creating Change

NEURODEVELOPMENTAL HISTORY

Person Completing Form: _____Relationship to Child: _____

Date Completed: _____ Who referred you to SB Solutions?:_____

Child

Name:_____ Child's Birthdate: _____ Age: _____ Sex:_____

Race/Ethnicity:_____ Preferred Pronouns: _____

Child's Status: Biological ☐ Adopted ☐ Other_____

Parents:

Legal Guardians (if not parents):_____

Marital Status of Legal Guardians:

Single ☐ Married/Committed Relationship ☐ Sep/Divorced ☐ Other_____

Parent Name:	Parent Name:
Relationship to Child:	Relationship to Child:
Parent Occupation:	Parent Occupation:
Highest Education Achieved:	Highest Education Achieved:

LIVING SITUATION:

Please list who lives in the household with the child (please use back of page if needed)

NAME:	AGE:	SEX:	RELATIONSHIP TO CHILD:

Please list parents and/or siblings who live outside the household

NAME:	AGE:	SEX:	RELATIONSHIP TO CHILD:

What is the main question that you hope we can answer about your child?

DEVELOPMENTAL HISTORY:

Pregnancy

Did mother have any illnesses or medical problems during pregnancy? YES ☐ NO ☐ UNKNOWN ☐

Specify:_____

_____

_____

Check for each problem the mother had during pregnancy:

Bleeding ☐ Infections ☐ Accidents ☐ Alcohol ☐ Cigarettes ☐ Recreational Drugs ☐

List any medications: _____

Delivery

Length of pregnancy (in weeks): _____

Type of delivery: Spontaneous ☐ Induced ☐ Caesarian ☐ Multiple Births ☐

Apgar Score (if known):_____ Birth Weight:_____

Did the mother have any complications during delivery? YES ☐ NO ☐

Check for each problem the mother had during delivery:

Forceps ☐ Eclampsia ☐ Vacuum ☐ Toxemia ☐ Fetal Distress ☐ Other: _____

Newborn Period

Check for each problem your child had at birth:

Breathing ☐ Turned blue ☐ Jaundice ☐ Infection ☐ Swallowing ☐ Seizures ☐ Feeding ☐ Incubator ☐

Other:_____ How long was your child in the hospital after delivery?: _____

Please describe any interventions your child needed following birth (ICU stay, oxygen, etc.):

_____

Check any of the following your child had in the first month of life:

Injury or infection ☐ Excessive crying ☐ Feeding difficulty/colic ☐

How would you describe your child's temperament in the first twelve months?:

Easy ☐ Difficult (clingy, fussy, cried excessively, etc.) ☐ Slow-to-warm-up ☐

When did your child begin to show these abilities?	**AGE**	**ANY CONCERNS?**
Sit without support:		
Crawl:		
Walk Alone:		
Sleep through the night:		

LANGUAGE AND COMMUNICATION SKILLS

When did your child begin to show these abilities?	AGE	ANY CONCERNS?
Pointing, gesturing and non-verbal communication		
Single word to name something, ie "ball" or "dog"		
Combine words into two- or three-word phrases		
Converse with two or more exchanges on the same topic		

Are languages other than English spoken at home? Yes ☐ No ☐ Languages:_____

By your child? Yes ☐ No ☐

Does your child speak clearly? Yes ☐ No ☐

Specify:_____

SOCIAL SKILLS

Does your child prefer group or individual activities? Group ☐ Individual ☐

How many friends does your child have? None ☐ One or two ☐ Some ☐ Many ☐

Are your child's friends: Younger ☐ Same age ☐ Older ☐ Mixed ages ☐

Check the behaviors that are problems for your child:

Avoids or dislikes social contact ☐ Reads social cues ☐ Initiation ☐ Maintains conversation ☐ Eye contact ☐

Describe other concerns with the child's social skills:_____

_____

EMOTIONAL DEVELOPMENT

Check the behaviors that are problems for your child:

Talking about emotions ☐ Identifying own emotions ☐ Identifying emotions in others ☐ Offering comfort to others ☐

Sharing joy with others ☐ Witnessed trauma ☐

BEHAVIORAL HISTORY

Please indicate if any of the following behaviors are problems for your child. As you answer the questions, consider if the behaviors are more problematic than you would expect for your child's age.

Check the behaviors that are problems for your child:

Difficulty with following directions at home ☐	Being easily distracted ☐
Frequently angry, loses temper a lot ☐	Frequently defiant, says no to adults ☐
Difficulty with following directions at school ☐	Restless, fidgety ☐

Whines or complains frequently ☐ Difficulty sitting still ☐ Poor safety awareness ☐ Is withdrawn ☐ Wanders or runs away ☐ Hurts him/herself ☐ Uncooperative ☐ Hyperactive, always on the go ☐ Sets fires ☐ Hurts animals or pets ☐ Hurts other people ☐ Tells lies ☐ Steals ☐ Other behaviors ☐ Describe:	"Tunes out," seems to be in own world ☐ Is sad or unhappy ☐ Impulsive, does things without thinking ☐ Is not able to separate from parent in familiar place ☐ Does not follow rules ☐ Has unusual movements (e.g., rocking) ☐ Makes noises such as clearing throat, grunting ☐ Cannot tolerate changes in routine ☐ Has many rituals or repetitive activities ☐ Has temper tantrums ☐ If yes, indicate frequency of tantrums: Has many fears ☐ If yes, name the specific fears:

EATING BEHAVIORS

Are there any concerns with eating or swallowing? Yes ☐ No ☐

Does your child have any food allergies? Yes ☐ No ☐ If yes, please list:_____

Check the behaviors that are problems for your child:

Unusual eating habits ☐ Selective eating ☐ Food refusal ☐ Challenging behaviors at mealtimes ☐

Binge-eating ☐ Purging ☐

TOILETING BEHAVIORS

When did your child begin to show these abilities?	AGE	ANY CONCERNS?
Toilet training - bladder		
Toilet training - bowel		
Toilet training - nights		

Does the child have frequent accidents? Yes ☐ No ☐ Describe:_____

SLEEPING BEHAVIORS

Bedtime during week: _____ Waking time during the week: _____

Bedtime on weekends: _____ Waking time on weekends: _____

Does your child take a nap? Yes ☐ No ☐

If yes, what is the typical time and length: _____

Check the behaviors that are problems for your child:

Wakes up frequently or early in the morning ☐ Has difficulty falling asleep ☐ Problem behaviors at bedtime ☐

Sleep terrors ☐

ASSESSMENT HISTORY

Has your child had any testing within the last 12 months (either school or outpatient)? Yes ☐ No ☐

What were the results of this testing? _____

Please use the tables below to describe any previous testing.

Assessment Type/Name of Assessor:	Year:	Results:

EDUCATION AND SERVICES

Does the child have an IEP or 504 Plan? Yes ☐ No ☐ In the past, not currently ☐

Specify:_____

_____

Does your child attend/receive the following:	Currently:	In the past:	Specify:
Special Education	Yes ☐ No ☐	Yes ☐ No ☐	
Speech Therapy	Yes ☐ No ☐	Yes ☐ No ☐	
Occupational Therapy	Yes ☐ No ☐	Yes ☐ No ☐	
Applied Behavior Analysis (ABA) Therapy	Yes ☐ No ☐	Yes ☐ No ☐	
Physical Therapy	Yes ☐ No ☐	Yes ☐ No ☐	
Early Intervention Services	Yes ☐ No ☐	Yes ☐ No ☐	
Psychiatric Services	Yes ☐ No ☐	Yes ☐ No ☐	
Other/Alternative Therapies	Yes ☐ No ☐	Yes ☐ No ☐	

ACADEMIC HISTORY

At what age did your child begin attending school:_____

What school does your child currently attend? Or, what is the last school s/he attended?_____

School address:_____

What is your child's current grade, or the last grade s/he completed?_____

Please list the schools your child has attended (continue on back of page if needed):

School Name	Grade(s)	Year(s)	Reason(s) for leaving

Has your child ever had difficulty being dropped off at school? If so, for how long? _____

_____

Within the past year, has the school reported problems with your child's: Reading? ☐ Spelling? ☐ Writing? ☐
Arithmetic? ☐ Behavior? ☐ Attention or concentration? ☐ Ability to follow directions? ☐ Social adjustment? ☐

How many days in the last year was your child absent from school?_____
What kinds of grades does your child typically earn?_____
Has your child ever been retained in a grade?_____
Briefly describe your child's academic performance:_____
_____

DIAGNOSTIC HISTORY

Please list any specific medical or mental health diagnoses the child has received, the year, and who made the diagnosis:

Diagnosis	Year	Diagnostician

MEDICAL HISTORY

Pediatrician:_____ Address: _____

Has your child been immunized? Yes ☐ No ☐

Has your child been tested for lead poisoning? Yes ☐ No ☐ Results:_____

Has your child had a hearing test? Yes ☐ No ☐ Age:_____ Results:_____

Has your child had a vision test? Yes ☐ No ☐ Age:_____ Results:_____

Does your child have a history of multiple strep infections? Yes ☐ No ☐

Has your child had any surgical procedures? Yes ☐ No ☐ Describe:_____

Has your child ever been seen by a neurologist? Yes ☐ No ☐

Has your child ever had seizure(s) or an abnormal EEG? Yes ☐ No ☐

Has your child ever had an MRI? Yes ☐ No ☐ Results:_____

Has your child ever had genetic testing? Yes ☐ No ☐ Results:_____

Has your child ever had a head injury or concussion? Yes - one ☐ Yes – multiple ☐ No ☐

Loss of consciousness? Yes ☐ No ☐ If yes, length of time unconscious _____

List any medical diagnoses or concerns:_____

_____

_____

List any medication (prescription or over-the-counter) your child takes now (include dose, frequency, and reason for medication):_____

_____

_____

List medications your child has taken in the last 2 years and discontinued (include name and reason for discontinuation):

_____

_____

_____

List supplements/vitamins/alternative treatments:_____

_____

FAMILY HISTORY

Is there any family history of illness, psychiatric problems or learning difficulties?

	Sibling	**Mother**	**Father**	**Mother's Family**	**Father's Family**
Autism, Asperger's, or PDD:	☐	☐	☐	☐	☐
Developmental delays:	☐	☐	☐	☐	☐
School or learning difficulty:	☐	☐	☐	☐	☐
Language or communication difficulty:	☐	☐	☐	☐	☐
Hyperactivity/ADHD:	☐	☐	☐	☐	☐
Intellectual Disability:	☐	☐	☐	☐	☐
Seizures/other neurological concerns:	☐	☐	☐	☐	☐
Tics/Tourette's:	☐	☐	☐	☐	☐

Genetic condition, such as Fragile X: Please specify: _____	☐	☐	☐	☐	☐
Anxiety disorder:	☐	☐	☐	☐	☐
Depression or other mood disorder:	☐	☐	☐	☐	☐
Personality disorder:	☐	☐	☐	☐	☐
Schizophrenia or other psychotic disorder:	☐	☐	☐	☐	☐
Alcohol/substance abuse:	☐	☐	☐	☐	☐
Criminal behavior:	☐	☐	☐	☐	☐
Other medical conditions: Please specify: _____	☐	☐	☐	☐	☐

PARENT/CAREGIVER STRESS

Please rate the amount of stress you (parent/caregiver) are currently experiencing:

	1 Little/None	**2**	**3**	**4 Moderate**	**5**	**6**	**7 Extreme**
At home:	☐	☐	☐	☐	☐	☐	☐
At work:	☐	☐	☐	☐	☐	☐	☐
With your child:	☐	☐	☐	☐	☐	☐	☐
With other family:	☐	☐	☐	☐	☐	☐	☐

Please comment on any of the above:_____

_____

_____

Please describe your child's strengths:_____

_____

_____

Thank you for completing this form. Please email to JSelman@SBSolutionsNY.com prior to your appointment.

Please bring any previous evaluations and pertinent school records (e.g., 504 plan/IEP) to your appointment.

Please complete this section if your referral question involves assessment for autism spectrum disorder.

PLAY AND LEISURE SKILLS

Does your child have preferred toys? Yes ☐ No ☐

Specify:_____

Check the behaviors that are problems for your child:

Prefers to play alone ☐ Does not imitate action in games☐ Does not play with toys as intended ☐

Does not do pretend play (e.g., talking on phone) ☐ Cannot have a conversation with another child ☐

Cannot take turns in play ☐ Does not use gestures to signal needs ☐ Lines up, spins, examines objects ☐

Describe other concerns with the child's play skills:_____

_____

_____

SENSORY FUNCTIONING

Check the behaviors that are problems for your child:

Is bothered by touch, smell, taste, sounds ☐ Describe:_____

Seeks out certain textures, smells, and objects ☐ Describe:_____

Is under or overly sensitive to pain ☐ Describe:_____

Describe any additional sensory seeking behaviors:_____

_____

RESTRICTIVE AND REPETITIVE INTERESTS

Check the behaviors that are problems for your child:

Have a pre-occupation or highly specific interest in a topic that is intense and time consuming ☐

Describe:_____

Demonstrates repetitive motor movements ☐

Describe:_____

Have a pre-occupation with parts of objects ☐

Describe:_____

Use words/phrases in a repetitive manner or echos words you use ☐

Adheres to nonfunctional routines ☐

Describe:_____

Insists on sameness ☐

Describe:_____