Developmental History Form C

Private and Confidential

|  |
| --- |
| **Demographic Information** |
| *To help us consider how to best manage your child’s referral, please can you answer as fully as possible* |

|  |  |
| --- | --- |
| Name of child/young person |  |
| Date of birth |  |
| Name(s) of the person(s) completing this form |  |
| Relationship to the child/young person |  |
| Date form completed |  |
| Who does the child/young person live with (please list all family members in household and ages and relationships to child, e.g. sister, mother, step-father) |  |

**Is there any family history of neurodevelopmental disorders (ADHD, Autistic Spectrum Disorder, learning issues including Dyslexia, Dyspraxia and Speech and Language problems, or emotional and mental health problems?  
Please circle:**

**Yes No**

*Please indicate if there is family history what their relationship to the child/young person is (e.g. close family = mother, father, sister, brother, extended family = grandparents, auntie, uncle, cousin) and if the condition is diagnosed, suspected or self-identified (e.g. older sister has ADHD, younger sister is autistic, I (mum) had post-natal depression when John was born.)*

**Has your child ever had an assessment for Neurodevelopmental difficulties (Autism Spectrum Disorder or Attention Deficit Hyperactivity Disorder)?**

**Please circle:**

**Yes                                                      No**

*Who completed the assessment? (e.g. Private Assessment by Psychiatrist, Emotional Health Service, emotional/mental health services, Neurodevelopmental Assessment Team, etc)*

*Where was the assessment completed?*

*What was the outcome of the assessment? (e.g. diagnosis of ADHD was given, did not meet criteria for a diagnosis of ASD)*

**Does the child/young person have problems with anxiety?**

**Please circle:**

**Yes                                                      No**

*If no specific triggers are identified, what signs of anxiety do they experience? (e.g. tearful, shaking, breathing really fast, gasping for air)*

*What is the impact of their anxiety? (e.g. refusing to go school, refusing to go to social engagements)*

*What is your understanding of where the anxiety stems from?*

*What support have they received?*

*When did the anxiety problems start?*

*How long have they been ongoing?*

*How frequently does the child/young person feel anxious and at what times of day?*

*Are there specific triggers for the anxiety? (e.g. worries around death, worries about school)*

**Does the child/young person have problems with low mood?**

**Please circle:**

**Yes                                                      No**

*If no specific triggers are identified, what are the signs of low mood? (e.g. tearful, unusually quiet)*

*What impact does this have? (e.g. withdrawing from social situations)*

*What is your understanding of what the low mood may be related to?*

*What support have they received?*

*When did the problem with low mood start?*

*How long has the low mood been ongoing?*

*How frequently do they experience low mood and what time of day?*

*Are there specific triggers for the low mood? (e.g. arguments with peers)*

**Does the child/young person have problems with their sleep?**

**Please circle:**

**Yes                                                      No**

*Do they have any issues with falling asleep?*

*Do they have any difficulties with staying asleep?*

*Do they have any difficulties with waking up in the morning?*

*How do they struggle? When did this start? How long have they been struggling with their sleep?*

*What impact does this have on the child/young person?*

*What is your understanding of what the problems are related to?*

*How many hours of sleep do they get on average per night?*

*What support have they received for this?*

**Has the child/young person had any significant life events or experiences which may have been overwhelming or stressful for them?**

**Please circle:**

**Yes                                                      No**

*What events or experiences have affected this? (e.g. moving homes/houses, moving schools/other significant transitions, loss of a loved one/pet, traumatic events, fighting/arguments at home, etc.)*

*What support have they received for this?*

**Has there been any previous involvement with emotional/mental health services?**

**Please circle:**

**Yes                                                      No**

*If yes, please elaborate: (e.g. Jane (John’s sister) had some CBT under the Emotional Health Service (EHS) but John hasn’t had anything. We try to use some of the CBT skills from Jane’s therapy to help John but it doesn’t seem to work very well).*

**Are there any additional stressor for family and child? (e.g. family illness, parental separation, loss, parental mental health issues)**

**Please circle:**

**Yes                                                      No**

*If yes, please elaborate:*

**Developmental History**

*You may wish to use the Red Book to fill out this section*

*Please make sure to provide examples/details if you tick ‘yes’ to any item(s)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **If yes, please give details here** |
| Were there any complications in the pregnancy or delivery of your child? (e.g. low birth weight) |  |  |  |
| Were there any significant problems with early eating/sleeping? |  |  |  |
| Was he/she/they difficult to bond with? |  |  |  |
| **Did your child have any problems in developing in the following areas:** |  |  |  |
| * Problems with Speech (how clear they sounded) |  |  |  |
| * Problems with Expressive language |  |  |  |
| * Problems with Understanding language |  |  |  |
| Was there ever a time when he/she/they seemed to lose language skills? |  |  |  |
| How old were they when they used words that you could understand?  How old were they when they first said something that involved putting words together meaningfully (2 or 3 word phrases?)  How old were they when they started speaking fluently? | \_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_ Months  \_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_ Months  \_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_ Months | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Motor and Coordination Difficulties** | **Yes** | **No** | **If yes, please give details here** |
| Did your child have problems with fine motor skills (buttons, laces, etc)? |  |  |  |
| Did your child have problems with handwriting? |  |  |  |
| Did your child have problems with gross motor skills (riding a bike, kicking a ball, etc)? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Other** | **Yes** | **No** | **If yes, please give details here** |
| Did your child have any early problems socialising (such as at nursery or playgroup)? |  |  |  |
| Did your child have any problems separating from their carers when a toddler?  *Please include how long this went on for and how easy/hard it was to soothe them.* |  |  |  |
| **As a toddler:** |  |  |  |
| * Were there any problems with activity levels? |  |  |  |
| * Did your child have problems focusing on one toy at a time? |  |  |  |
| * Did they have problems sitting still for things like meals? |  |  |  |
| * Was it difficult to manage them when you went out with them? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Other** | **Yes** | **No** | **If yes, please give details here** |
| * Were they impulsive (e.g. running out into the road)? |  |  |  |
| Has your child had any past significant medical difficulties (e.g. hospitalisations, sight or hearing issues, injuries, tics) |  |  |  |

|  |
| --- |
| How long has your child been having difficulties? |
| What is the impact of those difficulties on the child’s and family’s life (e.g. school life, friendships, mood, etc)? |

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you received any of the following support? If yes, please give details** | | | |
| Parenting Support group | **Yes** | **No** |  |
| Individual parenting support | **Yes** | **No** |  |
| Support from EWMH | **Yes** | **No** |  |
| Social care / Family support | **Yes** | **No** |  |
| Other | **Yes** | **No** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of School:** | | | |
|  | **Yes** | **No** | **If yes, please give details here:** |
| Does your child have an Individual Development Plan statement (IDP)? |  |  |  |
| Have they ever needed any specialist help in school? |  |  |  |
| Have they ever attended a special school? |  |  |  |
| Does your child enjoy school? |  |  |  |
| Has the school ever expressed concerns in any of the following areas: |  |  |  |
| * Learning |  |  |  |
| * Behaviour |  |  |  |
| * Relationships with other children |  |  |  |

**Social and Emotional History**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **If yes, please give details here:** |
| Does your child have any difficulties making or keeping friends? |  |  |  |
| Does your child have any problems with getting very emotional or very anxious? |  |  |  |

|  |  |
| --- | --- |
| What are your child’s interests? |  |
| What are your child’s strengths? |  |

**Social and Communication Skills**

|  |
| --- |
| **Please describe your child’s social skills, friendships,sociability**  **Please outline both strengths and challenges**  *Quality of friendships – are these long-term friendships? Are they often changing social groups/friends?*  *How is their ability to read social cues, body language?*  *Do they initiate social interactions with others?*  *How is their ability to reciprocate in conversations or have a ‘back and forth’ conversation?*  *Quality of play – playing together vs playing alongside others? How is their ability to take turns?* |

|  |
| --- |
| **Please describe their ability to communicate and express themselves**  **Please outline both strengths and challenges**  *How is their ability to communicate their thoughts and feelings?*  *How is their ability to participate in conversations around their inner world (e.g. thoughts, feelings)*  *Please describe any past concerns that have improved:* |

|  |
| --- |
| **How does your child manage change/being flexible (e.g. routines, being changed)?**  *How would they react to changes in plans/routines?*  *Are they able to be flexible around things such as rules and perspectives? (e.g. considering the point-of-view of others)*  *Has anything worked well in helping them manage change?*  *Does your child have highly specific interests? (If yes, please describe)*  *What interests are these?*  *How specific/extensive are these interests?*  *Do they speak about this interest very often/obsessively?*  *Does their interest appear normal for their age/peer group/development/current trends?* |

**Attention, Concentration, Activity and Impulsivity**

|  |
| --- |
| **Please describe any concerns around your child’s attention and concentration**  *When is their attention at its best?*  *If their attention is better in only specific situations, are they hyper focusing?*  *When is their attention at its worst?*  *How long are they able to concentrate for?*  *Can you give specific examples with context? (e.g. John really struggles to focus. We’ll be watching a movie but he won’t be able to follow the plot or focus on the movie for longer than 5 minutes. He’ll get distracted by random sounds or thoughts).* |

|  |
| --- |
| **Please describe any concerns around your child’s activity levels**  *Do they have larger signs of activity levels? (e.g. constantly on the go, bouncing off walls)*  *Do they have smaller signs of activity levels? (e.g. fiddling with things constantly, fidgeting, shaking legs all the time, shifting constantly in their seat)*  *Do their activity levels increase/decrease in certain situations?* |

|  |
| --- |
| **Please describe any concerns around your child’s impulsivity**  *Do they act without thinking?*  *Are they able to wait in a line/wait their turn?*  *Do they appear to lack an awareness of danger?* |

|  |
| --- |
| **What support has been put in place for the difficulties outlined in this form?** |

|  |
| --- |
| **What do you think would help?** |

**Child/Young Person’s View**

*This section can be filled in by the child/young person or in collaboration with the parent*

|  |
| --- |
| **How does the child/young person feel about the difficulties they are having?** |

|  |
| --- |
| **What do they think would help?**  *What is the child’s view on what support or help they need?*  *What is their view on seeking a diagnostic assessment for Autism and/or ADHD?* |