Aligned Clinical & Educational Services (ACES), PLC
CROZET MAILING ADDRESS: P.O. Box 28, Crozet, VA 22932
RICHMOND MAILING ADDRESS: P.O. Box 31436, Henrico, VA 23294
CROZET: 300 Claremont Lane, Suite 103, Crozet, VA 22932
RICHMOND: 8100 Three Chopt Road, Rm 127, Richmond, VA 23229
PHONE: (434) 466-1588 VP: (434) 326-1496 FAX: (866) 289-5249

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION FORM

for Psychological Assessment

Client Name: Client DOB:

Provider Name: Client Age:

Name of Person Completing this Form:

What is your relationship to this client?

What is your reason for seeking testing services for this child?

How were you referred to ACES?

FAMILY

Please list the people that live at home:

Name	Age	Gender	Relationship to Child

Parent / Guardian Information:

Parent / Guardian 1 Name:

Relationship to the Child Age of Parent / Guardian:

Education Level:

Occupation:

Parent / Guardian 2 Name:

Relationship to the Child Age of Parent / Guardian:

Education Level:

Occupation:

How would you describe the child's relationship with their family members?

What are your child's strengths?

What are your family's strengths?

What cultural, community, and/or spiritual supports are available to your family?

PREGNANCY AND DELIVERY

Check any of the following complications that occurred during pregnancy:

- ☐ Abnormal Weight Gain
- ☐ Alcohol Consumption
- ☐ Anemia
- ☐ Cigarette Consumption
- ☐ Cytomegalovirus
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Difficulty Conceiving
- ☐ Excessive Swelling
- ☐ Excessive Vomiting
- ☐ Flu
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Rh Incompatibility
- ☐ Toxemia
- ☐ Vaginal Bleeding

- ☐ Other substances/drugs used during pregnancy: _____
- ☐ Maternal Injury (Describe): _____
- ☐ Hospitalization: _____
- ☐ Medications used during pregnancy: _____
- ☐ Other Significant Complications:_____

Mother's age at birth: _____ Father's age at birth: _____

Was the child born in a hospital? ☐ Yes ☐ No

Length of pregnancy: _____ weeks

Length of labor: _____ hours Birth Weight: _____ lbs _____ oz

Apgar Score: _____ Birth Length: _____ inches

Please indicate any of the following complications that occurred during the birth:

- ☐ Breathing problems
- ☐ Breech birth
- ☐ Cesarean delivery
- ☐ Failed newborn hearing screening
- ☐ NICU stay for _____ days
- ☐ Other: _____
- ☐ Forceps used
- ☐ Incubator needed
- ☐ Labor induced

DEVELOPMENT

Please indicate the age for the following milestones and check the box that describes your child's acquisition of these skills compared to most children:

Skill	Age Acquired	Early	Expected	Late
Smile				
Crawl				
Interest in Sound				
Turn Over				

Skill	Age Acquired	Early	Expected	Late
Stand Alone				
First Words				
Sit Alone				
Walk Alone				
Speak Sentences				
Toilet Trained				

Was your child referred to early intervention or parent infant support? ☐ Yes ☐ No

If yes, what services were received? _____

Please indicate whether your child has experienced any of the following complications:

- ☐ Colic
- ☐ Difficulty learning to ride a bike
- ☐ Difficulty learning to skip
- ☐ Difficulty learning to throw or catch
- ☐ Difficulty separating from parents
- ☐ Excessive crying
- ☐ Failure to thrive
- ☐ Nursing or feeding problems
- ☐ Poor eye contact
- ☐ Repeating phrases or behaviors
- ☐ Sleep problems
- ☐ Temper tantrums
- ☐ Unclear speech
- ☐ Walking difficulty
- ☐ Other concerns about development_____

MEDICAL

Please check any illnesses that your child has had and indicate at what age:

- ☐ Anemia / Age:
- ☐ Broken Bones / Age:
- ☐ Chicken Pox / Age:
- ☐ Coma or Loss of Consciousness / Age:
- ☐ Diphtheria / Age:
- ☐ Encephalitis / Age:
- ☐ Frequent Strep / Age:
- ☐ Head Injury / Age:
- ☐ High Fever / Age:
- ☐ Lyme Disease / Age:
- ☐ Measles / Age:
- ☐ Meningitis / Age:
- ☐ Mumps / Age:
- ☐ Rheumatic Fever / Age:
- ☐ Scarlet Fever / Age:
- ☐ Seizures / Age:
- ☐ Tuberculosis / Age:
- ☐ Whooping Cough / Age:

Please note if your child has had any problems with hearing or vision:

- ☐ Ear Infections
- ☐ Ear Tube Placement
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Wears Glasses or Contacts

Date of Last Hearing Exam: _____ / _____ / _____

Date of Last Vision Exam: _____ / _____ / _____

Please list all medications, including vitamins and over-the-counter medications, taken on a daily basis:

Please name the people that make up your healthcare support team:

- ☐ Counselor/Psychologist/Social Worker: _____
- ☐ Psychiatrist:_____
- ☐ Pediatrician:_____
- ☐ Dentist: _____

- ☐ Speech-Language Pathologist: _____
- ☐ Occupational Therapist: _____
- ☐ Other: _____

Please indicate any family history of the following:

- ☐ AD/HD
- ☐ Anxiety/Obsessive Compulsive Disorder
- ☐ Autism/Asperger's
- ☐ Depression/Bipolar Disorder
- ☐ Gifted Education
- ☐ Learning problems
- ☐ Speech Problems
- ☐ Tourette's or Tic Disorder

Are there any other mental health or medical issues?

EDUCATION

Name of Current School: Grade:

Please list the names of each school-based program your child has attended and for how long s/he was in each setting, starting with preschool:

Name of Program	**Grade**

Has your child ever been retained a grade level? ☐ Yes ☐ No
Has your child ever been accelerated a grade level? ☐ Yes ☐ No
What are your child's academic strengths and weaknesses?

Do you have any concerns about school at this time?

Please indicate if your child receives any of these services:

- ☐ Special Education Accommodations
- ☐ Title 1 Reading Support
- ☐ Individual Education Program (IEP)

Please indicate for which area(s) your child qualifies for an IEP:

- ☐ Autism Spectrum Disorder
- ☐ Deafness
- ☐ Developmental Delay
- ☐ Emotional Delay
- ☐ Hearing Impairment
- ☐ Intellectual Disability
- ☐ Learning Disability
- ☐ Multiple Disabilities
- ☐ None
- ☐ Orthopedic Impairment
- ☐ Other Health Impairment (ADHD, etc.)
- ☐ Speech-Language Impairment
- ☐ Traumatic Brain Injury
- ☐ Visual Impairment

If your child has an IEP which classes do they attend? Please check all that apply:

- ☐ General Education
- ☐ Resource Room
- ☐ Special Education Class
- ☐ Special School or Residential Placement

SOCIAL/EMOTIONAL/BEHAVIORAL

What does your child enjoy doing during free time?

Describe your child's relationships or friendships with same-aged peers:

Does your child participate in any organized group, clubs, or sports?

How would you describe your child's personality?

How does your child cope with stress and express emotions?

Please indicate if your child has experienced any of the following:

- ☐ Accident Prone
- ☐ Aggressive Behaviors
- ☐ Anxiety
- ☐ Attention Problems
- ☐ Communication Delays
- ☐ Crying Spells
- ☐ Cutting or Self-Harm Behaviors
- ☐ Defiance
- ☐ Depression
- ☐ Difficulty Falling Asleep
- ☐ Early Morning Waking
- ☐ Excessive Complaints of Stomach Aches
- ☐ Excessive Weight Loss or Gain
- ☐ Extreme Fears
- ☐ Frequent Headaches
- ☐ Head Banging
- ☐ Hearing voices that are not really there
- ☐ Impulsive Behaviors
- ☐ Nightmares
- ☐ Obsessions/Compulsions
- ☐ Panic Attacks
- ☐ Repetitive Behaviors
- ☐ Seeing things that are not really there
- ☐ Sensory Integration Problems
- ☐ Social Isolation
- ☐ Suicidal Thoughts and/or Actions
- ☐ Tics
- ☐ Trouble with Police

Please include any supplemental information that you think might help us with our assessment. It's helpful for us to have information from previous evaluations (language assessments, prior intellectual assessments, report cards, Individualized Education Plans, SAT/ACT scores, etc.)