Colette C. Horn, Ph.D.
Psycho-Educational Assessments
35 Sundial Circle
Berlin, MD 21811
410-838-5270

DEVELOPMENTAL INVENTORY

Child's Name________________________________ Date of Birth__________ Age__________

Please list problems with which you want help for this child:________________________________

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List any current/past treatments or assessments for these problems (i.e., counseling, medication, etc)	Approximate Dates	Helpful? Y/N

Marital Status of Parents ______________If Separated/Divorced, age of child when this occurred__________________

Persons Living in the Home

Relationship (specify)	Name	Age	Education	Occupation
Mother/StepMother				
Father/StepFather				

Other Family Members Living with the Child:

Name	Age	Relationship (brother, sister, etc.)

List names and ages of any brothers or sisters living outside the home:________________________________

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Primary language spoken in home:________________Other languages spoken at home__________________

What are your child's favorite activities?________________________________

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What are your child's strengths?________________________________

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What activities does your child like least?________________________________

What type of discipline works best for this child?________________________________

What doesn't work?________________________________

Which of the following does your child have in his/her bedroom __TV, __CD/Tape Player, __Electronic Game System __Computer with games; __Computer with internet, __ books, __toys Child sleeps in __own bedroom, __bedroom shared with sibling, __parent's room, ,__other room (specify)____________________

Please put an X in the column of family members who have had one of these traits/illnesses:

Family History	Child's Mother	Child's Father	brother/sister	Other family member (specify) e.g., grandparent, cousin, uncle/aunt
Trouble learning to read				
Trouble learning math				
Attention/Hyperactivity Issues				
Depression				
Suicide Attempt				
Alcohol/Drug Abuse (Specify)				
Anxiety				
Obsessive-Compulsive Disorder				
Bipolar Disorder				
Panic Attacks				
Chronic Health Problem or Illness				
Other (Specify)				

Please check any of the following that are true for mother's pregnancy with this child:

Pregnancy History	Yes	No	Specify details, comments
Bleeding			
Toxemia			
Mother had to take medication (specify)			
Injury during pregnancy (specify)			
Drug use by mother during pregnancy (specify type & frequency)			
Alcohol use by mother during pregnancy (Specify amount)			
Cigarette use by mother during pregnancy (# per day)			
Difficult labor and delivery			
Cesarean section (specify reason)			
Premature delivery			(At what week was baby born?)

Baby's birth weight____________________ **Length of pregnancy**______________months

Infancy Problems	Yes	No		Yes	No	Comments
Born with cord around neck			colicky			
Injury during birth/Birth defects			poor sleeper			
Trouble breathing/Needed oxygen			needed to be held all the time			
Jaundice			irritable, fussy			
Had an infection			too active			
Had seizures			feeding problems			
Other infancy problem						

Developmental Milestones	Yes	No	Comments
Smiled by 8 weeks old			
Sitting up by 32 weeks old			
Standing by 36 weeks old			
Walking by 10 months old			
Speaking single words by 12 months old			
Speaking 2-3 word sentences by 30 months			
Bowel trained by 36 months			
Bladder trained by 60 months			

Educational History

School Name	Years/Grades	List any problems	Comments

Check "Yes" and specify age and comments if the child has had any of the following:

Health Conditions	Yes	Age	Condition	Yes	Age	Comment on any item checked
Broken bones			facial, vocal, or motor tics			
Operations/Surgeries			loss of consciousness			
Hospitalizations			dizziness			
Head injury			frequent or severe headaches			
Seizures			difficulty concentrating			
High Fevers			memory problems			
Ear Problems			rheumatic fever			

Health Conditions	Yes	Age	Condition	Yes	Age	Comment on any item checked
Eye Problems			epilepsy			
Allergies			tuberculosis			
Asthma			bone or joint disease			
Poor appetite			anemia			
Meningitis			jaundice/hepatitis			
Encephalitis			cancer			
Fever over 104 F			high blood pressure			
Fainting spells			heart disease			
Paralysis			bleeding problems			
Vision Problems			Poor Coordination			
Hearing Problems			speech or language problems			
Eczema/Hives			suicide attempt			
Diabetes			extreme tiredness/weakness			
Attention Problems			other (specify)			

School Problems	Yes	No	School Problems	Yes	No	Comments
Difficulty Reading/Decoding			Weak Arithmetic Facts			
Poor Reading Comprehension			Weak Arithmetic Word Problems			
Poor Spelling			Weak Math Reasoning			
Poor Handwriting			Refusal to go to School			
Weak Capitalization/Punctuation			Dislikes School			
Weak Sentence/Paragraph writing			Difficulty with homework			
Loses school papers			Bullied at school or on the bus			

Please place an X next to any behavior/problems that your child has now or had at a younger age. Explain under comments all items checked

Yes	***Emotional/Behavioral Concerns***	Yes		Comments
	difficulty getting along with siblings		panic attacks	
	difficulty getting along with peers		afraid to be alone	
	defiant of adult authority		can’t fall asleep	
	low frustration tolerance		wakes up during the night	
	frequent temper tantrums		frequent nightmares	
	irritable or angry		lethargic low energy	
	spiteful or vindictive		cries often or easily	
	aggressive		moody	

Yes	***Emotional/Behavioral Concerns***	Yes		Comments
	threatens or intimidates others		sad or depressed	
	injured parents, siblings, peers, pets		poor appetite	
	destroys objects on purpose		craves sweets or carbohydrates	
	talks too much		low self-esteem	
	impulsive		prefers to be alone	
	gives up easily		more interested in things than people	
	stubborn		difficulty with changes in routine	
	dangerous or daredevil behavior		sensitive to sounds, textures or other sensory stimuli	
	overly active		bangs head, pulls out hair, picks at skin, or otherwise injures self	
	grandiose, acts invincible		paranoid	
	frequently lies		avoids doing things other children enjoy	
	silliness or goofiness		frequent or intense rage	
	short attention span		self-stimulatory behavior	
	easily distracted		doesn't know how to play	
	disorganized		eats poorly (e.g., highly selective)	
	forgetful		has blank spells	
	can't follow directions		has bowel or bladder problems	
	clumsy		history of child abuse or sexual abuse	
	odd motor movements, mannerisms, habits		has lost a loved one, friends, or pet	
	repeats acts or behaviors over and over		startles easily	
	unusual or intense fears		preoccupied with death and dying	
	shy or timid		has lost interest in or avoids something that he/she used to enjoy	
	problems separating from parent		frequent headaches or stomach aches	
	sucks thumb		trauma history (e.g., dog bite, accident, etc.)	

Current medications, if any:______________________________

Name of Family Physician______________________________

Name of Private therapist, if any:______________________________

Is there any other information that you think may help us in evaluating this child? (Use reverse side of this sheet if needed.)

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