Wellington-Alexander
CENTER
DYSLEXIA ASSESSMENT & INTERVENTION

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Brief Developmental History

Child's name:			
Date of Birth:		Referred by:	
What are your primary concerns? (if any)			
Name of person filling out this form:		Relationship to child:	
Date form completed:			
Medical History: Please circle or fill in your responses as necessary			
Has your child ever experienced high or prolonged fevers?	**Yes/No**	Does your child have a history of chronic ear infections?	**Yes/No**
Does your child have any history of a serious illness? If yes, please list:	**Yes/No**	Has your child ever incurred a brain injury?	**Yes/No**
Does your child have a diagnosis of ADD or ADHD?	**Yes/No**	Does your child have any other diagnoses? If yes, please list on the back of this form.	**Yes/No**
Does your child have a history of hearing loss?	**Yes/No** **Date of Hearing Screening_____**	Does your child have a history of vision problems?	**Yes/No** **Date of Vision Screening_____**
Medication - list current medications:			
Developmental Milestone: Please fill in your responses			
At what age did your child use first words?		At what age did your child put 2-3 words together?	
At what age did your child sit unsupported?		At what age did your child take first steps?	
School History: Please circle in your responses			
Does your child struggle with reading?	**Yes/No**	Does your child struggle with spelling?	**Yes/No**
Does your child struggle with math?	**Yes/No**	Does your child struggle with comprehension?	**Yes/No**
Has your child received previous therapies? If yes, please list:	**Yes/No**		
Family History: Please circle in your responses			
Is there a family history of speech language and/or learning disabilities? (e.g. dyslexia)	**Yes/No**	Is there a family history of attention problems?	**Yes/No**

Please use the back of this form for any other information you wish to share.