**North Cumbria Children and Young People’s ADHD Service**

**Developmental History**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NHS NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Pregnancy: Were there health problems, substance/alcohol use, traumatic events?** |
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| **Birth: Birth weight:** **Delivery: normal, induced, caesarean, emergency delivery, forceps, Ventouse, SCBU?** |
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| **Developmental Milestones:** **Age the following milestones were achieved** |
| **Walking:** |
| **Talking:** |
| **Toileting:** |
| **If child or young person went to nursery, how did they get on there?** |
|  |
| **Please tell us about:** |
| **Appetite:** |
| **Sleep:** |
| **Please tell us if child or young person has sensory processing difficulties (such as higher or lower than expected reaction to sensory stimuli- sight, sound, smell, taste, touch, movement).** |
|  |

**Please return the completed history to** **CMB-ADHDNCumbria@cntw.nhs.uk**