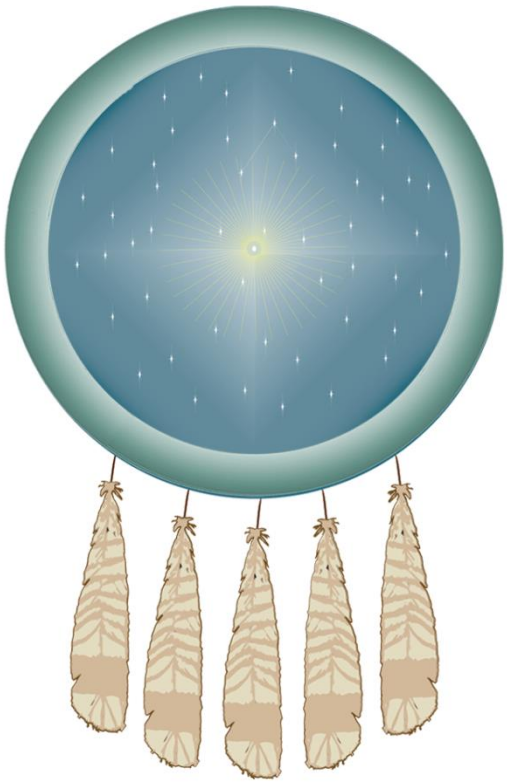
Medicine Wheel
Developmental History Form



Youth's name_____ D.O.B_____

Address_____Phone_____

Person Giving History_____ Relationship to youth_____

Person Taking History_____ Relationship to youth_____

Agency_____Date_____

The Circle

The Circle is sacred to traditional people all over the world. It reminds us that all of life is connected and continuous. Unbroken. No point on a circle is better than any other; it implies movement and flow. The circle helps us understand and respect the relationship of all things within a system and also the need for balance. This circle on the cover of the form was designed for the Elsipogtog Integrated Primary Health Care Project under the direction of Eva Sock.

Developmental History

The Medicine Wheel Developmental History, MWDH, is a semi-structured interview administered by a school counselor, nurse or social worker. It is designed to look at all factors in the child's history that might have influenced learning and development and contributed to problems. It can be helpful for gathering the pre-natal history and risk factors in screening for complex conditions.

The MWDH is divided into 4 domains-Social, Emotional, Physical, Mental -with questions reflecting developmental history in each of these areas. If the youth has been referred for further assessment because of multiple and complex needs the MWDH can be used as the intake form for the Children's Assessment Team.[1]

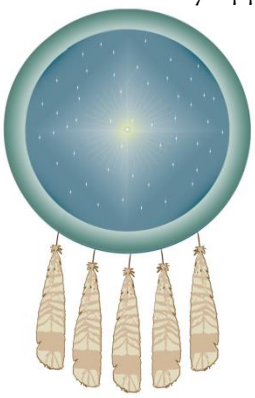
ADMINISTRATION

Administration Time

- The MWDH interview generally takes 60 minutes or more to complete.

When to Administer

- The MWDH interview is conducted by appointment as early in the school year as possible.



Range

- All students referred by teachers or parents with multiple problems severe enough to prevent them from learning in the regular classroom

Materials Needed

- Paper and pencil format
- Forms include information for administration

[1] It can also be used together with the *Medicine Wheel Student Index* as part of a staged screening process for FASD, fetal alcohol spectrum disorder.

Procedure for Interviewers

Parents sometimes lack trust in community service professionals; they are guarded and so can withhold important information, fearing the consequences. When administrating the *Medicine Wheel Developmental History*, it is essential to work collaboratively with the mother or guardian to create an environment safe enough for disclosure.

Creating an Environment Safe Enough for Disclosure

Take the time to connect with the person you are interviewing. Start by creating an environment that is physically comfortable and emotionally welcoming. Tell the person you are interviewing about the *Medicine Wheel Developmental History.*
Say:

- Whenever children have difficulty learning in the regular classroom teachers refer them so we can try to help the children learn by finding out why
- We know that children can't grow and learn unless their needs are met.
- So the purpose of the MWDH is to get to know your child's needs and strengths in all spheres: emotional, social, academic and physical

Interview Style

Use a semi-structured interview style. Generally try to keep on track but be flexible. Encourage the person to tell the story of their child's growth and development in their own words. Allow the person the freedom to talk; take the time to actively listen, to inquire and to create a real dialogue-otherwise it can feel like an interrogation. It is all in how you ask the questions and listen to the responses.

Establishing a Relationship

Try to establish a non-judgmental collaborative relationship. Acknowledge the mom's strengths and capabilities. Emphasize her ability to make choices, and the opportunity she has to make things better. Use the interview process to help build a positive, working relationship with the mom (or guardian) and the family. It is possible to maintain a healthy boundary while collapsing the usual top-down professional distance.

Normalizing Disclosures

Normalize any disclosure, that is, do not react to any information shared even if it would normally shock you. Never judge, even if you disapprove. Remember that each person is doing the best they can--try to walk in their shoes and understand the world from their perspective. It is especially important to normalize any disclosure of drinking, drugging, abuse, etc. Without encouraging the behavior take the time to be supportive and sympathetic.

The Interview Process

The interview is set up to start with areas that are neutral and non-threatening, like name, age, address etc. It moves on to the presenting problem, that is, the problems they or their children are having. If they have initiated the session you can ask: 'what brings you here today?' If the child was referred by the teacher you can ask: 'what are your concerns about your child?' People usually like to talk about their family, their children, and extended family support system. So areas like family and social history are usually good places to start with to get a real conversation going. Gradually move on to more difficult areas of discussion.

An especially important but sensitive area is the pregnancy history. Only move on to pregnancy history when you have established a good rapport. Specific questions regarding prescription drugs, cigarettes, caffeine, alcohol, grass, and other drugs during pregnancy are included in the developmental history because exposure to these may have affected the child. Remember to probe gently and to get specifics: patterns of substance use during pregnancy and also before they knew they were pregnant.

Often women are relieved when they disclose risky behaviors during pregnancy if they feel that they are in a supportive non-judgmental setting. You can take the opportunity to reassure them if they seem to feel guilty. Explain that people do what they think is best at the time they do it. We can't go back and change the choices we made in the past but we do have the opportunity to make things better. Taking the time to get help is the first step. Always keep on the positive.

After the Interview

At the end of the interview explain to the parent if you think referrals should be made to other specialists to learn more about child's needs. Tell her that if a child is not learning it just means we have not yet found the right way to teach them. (Marie Clay) Thank the mom for giving her time and let her know that this is the first step in working together to get her child any help he or she needs.

1 The Center ~ The Child

1. Child's Name:_____ Medical #: _____Sex_____
   Date of Birth: _____Place of Birth:_____

2. Child's Family Doctor
   Name: _____
   Address: _____
   Telephone: _____

3. Referral Source _____

4. Parents-Fill All That Is Applicable

	Birth Mother	Birth Father	Guardian
Name			
Birth Date			
Education Level			
Occupation			
Home Telephone			
Work Telephone			
Home Address			

	Adoptive Mother	Adoptive Father	Foster Mother	Foster Father
Name				
Birth Date				
Education Level				
Occupation				
Home Telephone				
Work Telephone				
Home Address				

Notes

The Center ~ The Child

PRESENT DIFFICULTIES AND STRENGTHS

5. Would you tell me a bit about your child? What would you say are his/her strengths or special gifts? In school? Out of school?

_____
_____
_____
_____

6. What are your Child's favorite activities?

a. _____ b. _____ c._____

7. What activities does your child like least?

a. _____ b. _____ c._____

8. Can you tell me a bit about your child's difficulties?

_____
_____
_____
_____

9. How long have you been worried about these problems?

_____
_____
_____
_____

10. What seems to help your child and what seems to make things worse?

_____
_____
_____

11. Has your child had any help for these or other problems?
Yes _____ No _____

12. If yes, when and with whom? _____
_____
_____
_____

II *Social History*

1. Parent's marital status:

a. _____ Single
b. _____Married
c. _____Separated
d. _____Divorced
e. _____Common-Law

2. If parents are separated, how old was the Child when separation occurred? _____

3. Child lives primarily with:
a. _____Mother
b. _____Father
c. _____Both parents
d. _____Other (please name) _____

4. Number of brothers and sisters: _____

5. Please list

Name of Sibling (oldest to youngest)	Birth Date	Age	Grade	Living Home

Notes

II *Social History*

6. List all other people living in the household

Name	Relationship to Child	Age

7. Does your child have a best friend or children that he/she is close to? (Please Name)

_____
_____
_____

8. Does your child have a problem with bullying? Gets Bullied _____Is a Bully____

Family Culture

9. What is the first language of:
a. mother _____ b. father _____ c. Child _____

10. Which languages are used between:
a. mother & father _____ c. father & child _____
b. mother & child _____ d. siblings & child _____

11. Does your family have a spiritual or religious affiliation?

a. Church Affiliation_____
b. Traditionnel _____
d. No spiritual practice_____

12. How important is it to you?

_____
_____
_____

III *Emotional History*

A) TRAUMA – ABUSE-please check all that apply

From what you have observed do you think it is likely that your child has been involved with, witnessed or experienced:

	Age when started	What substance	How much and how frequently	Did you ever get help or report—To whom	Would you like help for your child
Drinking					
Sniffing					
Drugs					
Cigarettes					
Family Violence					
Traumatic Event					
Sexual Abuse					
Physical Abuse					

B) SUICIDE & GRIEF- Has your child ever:

1. Talked about suicide ____ If so, when _____
2. Attempted suicide ____ If so, when _____
4. Hurt themselves on purpose (ie slashing, cutting) ____ If so, when_____
5. Has your child experienced the death of someone close to them_____
6. If so, what were the circumstances? _____

C) ATTACHMENT--please check all that apply

1. Does your child have a special relationship with someone in the family or community Yes_____ No_____
2. If yes, with whom _____
3. Has your child ever lived with anyone else but you_____
4. How many places have they lived-including foster care _____
5. List placements below:

With Whom?	How Long?

IV *Physical*

A) Background

1. **Family Learning History**-Please indicate if anyone in the child's birth or extended family has had problems in the following areas:

Problems	(a) Childs Brothers or Sisters	(b) Mother (Bio))	(c) Father (Bio)	(e) Mother's Family	(f) Father's Family
1. Trouble learning spell-read					
2. Trouble with arithmetic					
3. Speech- language problems					
4. Repeated Grades					
5. Diagnosed ADHD					
6. Diagnosed learning or developmental disabilities					
7. Diagnosed FASD					

2. **Biological Family Health and Trauma History**

Can you tell me about your family's health and trauma history?

Place a check next to any condition that you or any member of the child's birth or extended family has experienced. Please note the relationship to the child.

Problems	(a) You Mom (Bio)	(b) Father (Bio)	(c) Granparent Mothers	(d) Granparent Fathers	(e) Mothers Family	(f) Fathers Family
1. Residential School						
2.Mental Health (Include anxiety, depression)						
3.Suicide-or Attempts						
4.Gambling Problems						
5. Alcohol Problems						
6. Drug Problems						
7. Treatment If Bio Mom (Note Date)						
8, Family Violence						
9.Abuse (physical or sexual)						
10 Trouble with the law						

IV *Physical*

Medical Conditions

3. Has your child ever had any serious illnesses? _____
4. Is your child on any medication at this time? Yes _____ No _____
   Please specify medication _____
5. Does your child wear glasses? Yes__ No__
6. Has their vision been checked in the last 12 months? Yes__ No__
7. Do they wear a Hearing Aid? Yes__ No__
8. Has their hearing been checked in the last 12 months? Yes__ No__
7. Has your child ever been hospitalized?_____

Check	Illness or Condition	Date(s) or Age
_____	a.-Measles	_____
_____	b.- Meningitis	_____
_____	c.- Encephalitis	_____
_____	d- High fever	_____
_____	e.- Convulsions	_____
_____	f- Allergies	_____
_____	g.- Asthma	_____
_____	h.- Head Injuries	_____
_____	i.- Operations	_____
_____	j.- Fainting spells-loss of consciousness	_____
_____	k.- Ear problems (disease, impaired hearing)	_____
_____	l.- Dizziness	_____
_____	m- Frequent or severe headaches	_____
_____	n.- Bed-wetting/soiling	_____
_____	o.- Epilepsy	_____
_____	p- Anemia	_____
_____	q.- Diabetes	_____
_____	r.- Cancer	_____
_____	s- Heart problems	_____
_____	t.- Other_____ .	_____

Notes

IV *Physical*

8. PREGNANCY HISTORY

a. About how far along were you in your pregnancy before you knew you were pregnant? _____

b. Were you taking any drugs prescribed by the doctor then?

i. If yes, what were you taking?_____

c. **What about cigarettes?**

Before you knew you were pregnant did you smoke?_____

How much? How often?

d. **What about marihauna or other drugs ?**

Before you knew you were pregnant did you use marihauna or any other drugs help you relax? _____

What kind? How much? How often?

	Substance	Average Amount	Maximum Amount	Frequency # Days Per Week
Before Preganacy	Cigarettes			
	Cannabis			
	Opiates			
	Other (Name)			

e. Can you remember before you got pregnant what was your usual drinking style ?

non-drinker_____ infrequent _____ weekends_____daily_____

f. If you were a drinker do you remember about how much you could drank-could hold- before feeling it_____

What kind of alcohol ? How much on average ? How often did you drink? (see chart below)

	Substance	Average # Drinks	Maximum # Drinks	Frequency # Days Per Week
Before Preganacy	Wine			
	Beer			
	Liquor			
	Other (Name)			

g. Did your drinking style change when you became preganant?

h. If you were a drinker when during your pregnancy did you have your last drink?

Trimester	
First 1-3 months	
Second 4-6 months	
Third: 7-9 months	

i. Can you describe your drinking style when pregnant?

	Substance	Average # Drinks per Occasion	Maximum # Drinks	Frequency # Days per Week
During Preganacy	Wine			
	Beer			
	Liquor			
	Other (Name)			

j. Did you use any other substances during your pregnancy? _____ If so when?

Trimester	
First 1-3 months	
Second 4-6 months	
Third: 7-9 months	

Please describe:

	Substance	Average Amount	Maximum Amount	Frequency of Use # Days Per Week
During Preganacy	Cigarettes			
	Cannabis			
	Opiates			
	Other (Name)			

k. Was the father of your child a heavy user of alcohol? Yes _____ No____

l. Drugs? Yes _____ No _____

m. ALTERNATIVE KEY INFORMANT QUESTIONS

If the person being interviewed is not the birth mother please inquire about what they know about the birth mother's pregnancy history

Substances Used	How Much	How Often	Confirmed	Suspected
1. Prescription Drugs				
2. Other Drugs				
3. Smoking				
4. Alcohol				

n. Did you receive prenatal care throughout your pregnancy? Yes____ No_____

o. Do you remember if you had anemia or low iron during pregnancy? Yes____ No_____

p. Sometime people suffer from nausea when pregnant and have difficulty eating especially early in the pregnancy. Do you remember what you normally ate when pregnant?
Nutritional Chart

Food Groups	Milk, Cheese Yogurt	Meat, Eggs Fish	Fruit Vegies	Potatos Grains	Caffine
First 1-3 months					
Second 4-6					
Third: 7-9					

q. Were you hit or hurt during pregnancy? Yes____ No_____
(If the mother was abused probe gently an d ask her if she would like to talk with someone)

r. Did you handle raw meat or game during your pregnancy or handle cat litter? Yes____ No_____

s. Were forceps used during delivery? Yes ___No ___
a. If yes, for what reason?_____

t. Was a caesarian performed? Yes ___No ___
a. If yes, for what reason? _____

u. Was your child premature? Yes__ No____
a. If so, by how many weeks?_____

v. Were there any birth defects or complications? Yes_____ No _____
a. If yes, please describe. _____

w. What was the birth weight of your child? _____
x. What was your age at birth? _____

y.. Did you breastfeed? _____ How long? _____
z. Did you use drugs or alcohol after the baby was born_____
_____
_____

Is there anything else about your pregnancy you would like to mention?
_____
_____
_____
_____

IV *Physical*

9. NEONATAL HISTORY AND INFANCY

A. Did the following problems occur during the first few weeks of life?

Problem	No	Yes	Comments
a.- Placed in incubator			
b.- Blood transfusions			
c.- Jaundice			
d.- Problems breathing			
e.- Problems feeding			
f.- Convulsions			
g.- Other (specify)			

B. Did the baby leave the hospital with the mother?
_____ Yes _____ No Comments: _____

C. Did the baby have colic?
_____ Yes _____ No Comments: _____

D. As an infant did the Child like to be held?
_____ Yes _____ No Comments: _____

E. Was the child alert as an infant?
_____ Yes _____ No Comments: _____

F. In general, how would you best describe your child's behavior during the first 2 years of life? a. Easy _____ b. Difficult _____ c. Other _____

G. Were they any special problems in growth? _____

V *Mental -Cognitive Development*

DEVELOPMENTAL MILESTONES

1. At what age did your child do the following? Guestimate

Behavior	Age	Behavior	Age
a. Roll over		g. Babble	
b. Sit alone		h. Speak first word	
c. Crawl		i. Put several words together	
d. Walk alone		j. Feed self	
e. Ride tricycle		k. Become toilet trained	
f. Dress self		l. Stay dry all night	

BEHAVIOR CHECKLIST

Mild- 1- Occasionally Moderate- 2- Often Severe -3- Very Often

Severity Planning/Temporal Skills

1 2 3 Needs considerable help organizing daily tasks_____
1 2 3 Cannot organize time_____
1 2 3 Does not understand concept of time_____
1 2 3 Difficulty in carrying out multi-step tasks_____

Self-Regulation/ Affect Regulation

1 2 3 Poor management of anger/tantrums_____
1 2 3 Mood swings_____
1 2 3 Impulsive (doesn't think before acting) _____
1 2 3 Compulsive_____
1 2 3 Perseverative _____
1 2 3 Attention (flips from one thing to another or hyper-focuses) _____
1 2 3 Inappropriate (high or low) activity level)_____
1 2 3 Lying/Stealing_____
1 2 3 Other _____

Abstract Thinking/Judgement

1 2 3 Poor judgement_____
1 2 3 Cannot be left alone_____
1 2 3 Concrete, unable to generalize or think abstractly_____
1 2 3 Other_____

Memory/Learning/ Information Processing

1 2 3 Poor memory, inconsistent retrieval of learned information_____
1 2 3 Slow to learn new skills_____
1 2 3 Does not seem to learn from past experiences_____
1 2 3 Problem recognizing the consequences of actions_____
1 2 3 Problem with processing information_____
1 2 3 Other_____

Spatial Skills and Spatial Memory

1 2 3 Gets lost easily, has difficulty navigating from point a to point b
1 2 3 Other

Social Skills and Adaptive Behavior

1 2 3 Acts much younger than age_____
1 2 3 Poor social skills/adaptive skills_____
1 2 3 Very talkative but poor comprehension_____
1 2 3 Other_____

Motor Skills

1 2 3 Poor/delayed motor skills_____
1 2 3 Poor balance _____
1 2 3 Poor Coordination_____
1 2 3 Other_____

V Mental -Cognitive Development

SCHOOL HISTORY

3. Has your child ever been left back in school? Yes _____ No _____
   Grades_____

4. Has your child ever been suspended or expelled from school?
Never_____ A few times _____Frequently _____Is now suspended or expelled_____

PROBLEM AREAS

5. Please indicate if the child has had:

Problem	*Never Problem*	*Present Problem*	*Past Problem*
A. Trouble learning to read or spell			
B. Trouble with arithmetic			
C. General academic problems			
D. Behavior problems			
E. Other school problems-Name			
F. Liking school			

6. Sensory

a. Is your child sensitive to bright lights? Yes _____ No _____
b. Is your child sensitive to loud sounds? Yes _____ No _____
c. Is your child sensitive to certain textures? Yes_____No_____

7. Sleep

Does your child:

a. Have difficulty falling asleep_____
b. Wake up at night_____
c. Have nightmares_____
d. Have excessive daytime sleepiness_____
e. Have restless sleep_____
f. Snore when sleeping_____
g. Have sleep apnea_____

8. Which hand does the child use for writing? a.__ left b. __ right c. __both

9. Provide any information you have concerning assessments received by your Child (Attach reports if possible).

Assessments	No	Yes	Date	Age	Place	Name of Professional
a. Educational						
b. Sensory-Motor						
c. Speech-Language						
d. Occupational Therapy						
e. Other-(Name)						

Agency Involvement

10. Has the Child ever been involved with the following community agencies?

Agency	No	Yes	When	Reason
a. Mental Health/Psychological Services				
b. Social Services				
c. Police				
d. Drug and Alcohol Treatment				
e. Other				

Parenting

11. What disciplinary techniques do you usually use when your Child behaves inappropriately?

_____
_____
_____
_____

12. What have you found to be the most satisfactory ways of helping your child?

_____
_____
_____

What are your hopes for your child's future?

Is there any other information that you think may help us in working with your child?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
Signature of Informant

Thank You