

DEVELOPMENTAL HISTORY

Child's Name _____ D.O.B. _____

Parent's/Guardian Name _____ Date: _____

Primary Physician _____

Referring Physician _____ Reason for Referral _____

Diagnosis _____

Other MD/ Specialists child sees _____

Family History

Mother _____ DOB _____

Father _____ DOB _____

Names and ages of child's siblings:

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Language spoken at home _____

Language understood by child _____

Language spoken by child _____

Prenatal History

Mother's age at child's birth _____

Any problems with the pregnancy? _____

Did mother require medication? _____

Number of previous miscarriages _____

Birth History

Length of pregnancy: Full Term _____ Premature _____

If premature, give number of weeks _____

Delivery: Vaginal _____ Cesarean Section _____

Birth weight _____ APGAR scores _____

Were there other complications? (Check all that apply)

____ Breathing difficulties _____ Congenital defects

____ Jaundice _____ Transfusions

____ Tube fed _____ Seizures

____ Feeding difficulties _____ infection

____ Intra-ventricular hemorrhage (bleed in brain) - Grade _____

Was your child in the NICU _____ or regular nursery _____

Length of hospitalization _____

Age at discharge _____

Developmental History

At what age did your child:

Roll over _____ Sit alone _____ Crawl _____

Walk _____ Potty Train _____

Develop hand preference _____ (right) _____ (left)

When did your child say his/her first words? _____

When did your child begin to combine words? _____

Did /does your child:

____ Sensory

- | | |
|---|---|
| <input type="checkbox"/> have trouble falling asleep | <input type="checkbox"/> avoid being touched |
| <input type="checkbox"/> engage in self-stimulatory behaviors | <input type="checkbox"/> hear things most people tune out |
| <input type="checkbox"/> react negatively to "normal" noises | <input type="checkbox"/> refuse to wear certain clothing/textures |
| <input type="checkbox"/> fear climbing | <input type="checkbox"/> is always in motion |
| <input type="checkbox"/> fall frequently | <input type="checkbox"/> dislike certain tastes |
| <input type="checkbox"/> dislike certain temperatures | <input type="checkbox"/> dislike certain textures |

How would you describe your child:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> cooperative | <input type="checkbox"/> easily frustrated |
| <input type="checkbox"/> withdrawn | <input type="checkbox"/> irritable |
| <input type="checkbox"/> aggressive | <input type="checkbox"/> other – describe: _____ |
| <input type="checkbox"/> happy | |

Has your child had a hearing test? _____
 When _____ Results _____

Has your child had a vision test? _____
 When _____ Results _____

Is your child currently receiving any of the following:

Speech and Language service _____	Where _____
Occupational Therapy _____	Where _____
Physical Therapy _____	Where _____
Adaptive equipment used at home _____	

School Information

Child's school _____ Grade _____
 Teacher's name _____
 Child's relationship with classmates _____
 Areas of academic difficulties _____
 Areas of most success/enjoyment _____

Parent's/child's concerns (with child, therapy, funding, etc.)

Parent's/child's goals in therapy

