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Developmental History for Therapy Services

Child's Name: ___________________________ Date: _______________

Birthdate: _______________ Mother's Age at Child's Birth: _______

Allergies: ________________

Please check the column which best describes your child. After each item and category, please write any remarks or comments that you feel may be helpful. Please include your child's strengths in the comment section.

Before Birth	**Yes**	**No**	**Remarks**
1. Where there any illnesses, injuries, fainting spells, Bleeding, anemia, operations or other difficulties?	___	___	____________
2. Were any drugs or medications taken during pregnancy? Please specify: ___________________________________	___	___	____________

Delivery	**Yes**	**No**	**Remarks**
1. Was the pregnancy full term?	___	___	____________
2. Was the pregnancy premature? (Give months and birth weight): ____________________	___	___	____________
3. Was it an unusual delivery? (Breech, C-section, Specify): _______________________	___	___	____________
4. Was the labor normal?	___	___	____________
5. Was the labor abnormal? (Prolonged, short, specify): ________________	___	___	____________
6. Were forceps used? (Give details)	___	___	____________
7. Was any medication given during delivery? (If yes, please specify): ____________________	___	___	____________

Birth	**Yes**	**No**	**Remarks**
1. Was your child considered to be low birth weight?	___	___	____________
2. Were there complications such as:			
A. Cyanosis	___	___	____________
B. Jaundice	___	___	____________
C. Congenital Defects	___	___	____________
D. Limpness	___	___	____________
3. Was there a need for:			
A. Oxygen	___	___	___________
B. Transfusions	___	___	___________
C. Tube Feedings	___	___	___________
4. Were there any feeding difficulties?	___	___	___________
5. Was the child bottle-fed or breast-fed?			___________
6. Did the child have problems sucking?	___	___	___________

Medical History	**Yes**	**No**	**Remarks**
1. Has your child had any of the following? (Please give dates and indicate whether the child Had the illness or was immunized.)			
A. Meningitis	___	___	___________
B. Measles	___	___	___________
C. Chicken Pox	___	___	___________
D. High Fevers	___	___	___________

	Yes	**No**	**Remarks**
E. Mumps	___	___	____________
F. Whooping Cough	___	___	____________
G. Scarlet Fever	___	___	____________
H. Convulsions	___	___	____________

	Yes	**No**	**Remarks**
I. Diabetes	___	___	____________
J. Lung or bronchial difficulties	___	___	____________

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	Yes	No	Remarks
K. Heart trouble	___	___	____________
L. Seizures (indicate when & how often)	___	___	____________
M. Allergies (please specify each)	___	___	____________
N. Excessive Vomiting	___	___	____________
O. Reflux	___	___	____________
P. Tuberculosis	___	___	____________
Q. Polio	___	___	____________
R. Physical Injuries	___	___	____________

(Please describe):

____

____

2. Does your child have any vision problems?	___	___	____________
3. Has your child had an eye evaluation?	___	___	____________

Doctor: _________________

Date: ___________________

4. Does your child have a hearing problem?	___	___	____________
5. Has your child had a hearing evaluation?	___	___	____________

Doctor: _________________

Date: ___________________

6. Is your child currently on any medications?	___	___	____________

(List medications and reason for taking them):

Surgery History	**Yes**	**No**	**Remarks**
1. Has your child had any surgeries?	___	___	________

(Please list all surgeries and dates):

____

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Developmental History

	Age		
1. At what age did your child:			
A. Roll over both ways?	___		
B. Sit Alone?	___		
C. Walk?	___		
D. Speak his first word? (What was the word)	___	Word:	_____________
E. Speak his first sentence? (What was it)	___		
F. Drink from a cup independently?	___		
G. Use a spoon independently?	___		
H. Feed himself independently?	___		

2. Describe your child as an infant:	Yes	No	Sometimes
A. Cries often, fussy, irritable	___	___	_____
B. Is good, non-demanding	___	___	_____
C. Is Alert	___	___	_____
D. Is quiet	___	___	_____
E. Is passive	___	___	_____
F. Is active	___	___	_____
G. Likes being held	___	___	_____
H. Resists being held	___	___	_____
I. Is floppy when held	___	___	_____
J. Is tense when held	___	___	_____
K. Has good sleep patterns	___	___	_____
L. Has irregular sleep patterns	___	___	_____

3. Describe your child at present	Yes	No	Sometimes
A. Is mostly quiet	___	___	_____
B. Is overactive	___	___	_____
C. Tires easily	___	___	_____
D. Talks constantly	___	___	_____
E. Too impulsive	___	___	_____
F. Is restless	___	___	_____
G. Is stubborn	___	___	_____
H. is resistant to changes	___	___	_____
I. Over reacts	___	___	_____

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	Yes	No	Sometimes
J. Fights frequently	___	___	_____
K. Is usually happy	___	___	_____
L. Exhibits frequent temper tantrums	___	___	_____
M. Is clumsy	___	___	_____
N. Has difficulty separating from primary caretaker	___	___	_____
O. Has nervous habits or tics	___	___	_____
P. Falls often	___	___	_____
Q. Has poor attention span	___	___	_____
R. Is frustrated easily	___	___	_____
S. Has unusual fears	___	___	_____
T. Rocks self frequently	___	___	_____
U. Has difficulty learning knew tasks	___	___	_____

Language	**Yes**	**No**	**Sometimes**
1. Does your child seem to understand what is said to him?	___	___	_____
2. Did your child start to talk and then stopped?	___	___	_____

Sensory History	**Yes**	**No**	**Sometimes**
Does your child:			
1. Respond negatively to unexpected loud noises?	___	___	_____
2. Have difficulty paying attention when there are other Noises nearby?	___	___	_____
3. Miss hearing some sounds?	___	___	_____
4. Seem confused as to the direction of sounds?	___	___	_____

	Yes	No	Sometimes
5. Seem t enjoy strange noises or make loud noises?	___	___	_____
6. Appear to be hard of hearing?	___	___	_____
7. enjoy music?	___	___	_____
8. have a diagnosed hearing loss?	___	___	_____

Gustatory-Olfactory-Elimination	**Yes**	**No**	**Sometimes**
Does your child:			
1. acts as though all food tastes the same?	___	___	_____
2. chew on non-food objects?	___	___	_____
3. have unusual craving for certain foods?	___	___	_____

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	Yes	No	Sometimes
4. dislike food of certain textures?	___	___	_____
5. explore by smelling?	___	___	_____
6. discriminate odors?	___	___	_____
7. react negatively to smell?	___	___	_____
8. ignore unpleasant odors?	___	___	_____
9. have trouble with constipation?	___	___	_____

Visual	Yes	No	Sometimes
Does your child:			
1. Appear happier in the dark?	___	___	_____
2. Pick up pictures or objects and look very closely And carefully at them?	___	___	_____
3. resists having eyes covered?	___	___	_____
4 Become excited when there is a variety of visual objects?	___	___	_____
5. Squint often?	___	___	_____
6. have difficulty with visually focusing on things far away?	___	___	_____
7. have difficulty with visually focusing on things close?	___	___	_____

Tactile/Touch	Yes	No	Sometimes
Does your child:			
1. Avoid playing with "messy" things, i.e. finger paint, Paste, mud, sand, etc?	___	___	_____
2. Dislike having his face washed or wiped?	___	___	_____

	Yes	No	Sometimes
3. Appear to be irritated by cloth of certain textures? Describe:___________________________________	___	___	_____
4. object to being touched?	___	___	_____
5. dislike being touched unexpectedly?	___	___	_____
6. dislike being cuddled?	___	___	_____
7. prefer to touch rather than be touched?	___	___	_____
8. avoid using hands for extended periods?	___	___	_____
9. bang his head on purpose now or in the past?	___	___	_____
10. pinch, bite, or otherwise hurt himself?	___	___	_____
11. pinch, bite, or otherwise hurt others?	___	___	_____
12. examine objects by putting them in his mouth?	___	___	_____

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	Yes	No	Sometimes
13. tend to feel less pain than others?	___	___	_____
14. tend to feel pain more than others?	___	___	_____

<u>Motor</u>	**Yes**	**No**	**Sometimes**
Can your child:			
1. Hop on one foot?	___	___	_____
2. Skip?	___	___	_____
3. Jump with both feet together?	___	___	_____
4. Ride a tricycle?	___	___	_____
5. Ride a two-wheeler with or without training wheels?	___	___	_____
6. Pump self on a swing?	___	___	_____
7. Kick a ball?	___	___	_____
8. Throw a ball?	___	___	_____
9. Catch a ball?	___	___	_____

Does your child exhibit difficulty with:	**Yes**	**No**	**Sometimes**
1. cutting or pasting?	___	___	_____
2. small manipulative toys?	___	___	_____
3. learning to hold a pencil or crayon in a 3point position?	___	___	_____
4. learning how to use playground equipment?	___	___	_____

Comments:

<u>Social Adjustment</u>	**Yes**	**No**	**Sometimes**
Does your child:			
1. Find it hard to make friends among his peers?	___	___	_____
2. Prefer the company of adults, or older children?	___	___	_____
3. Prefer to play with younger children?	___	___	_____
4. Frequently express feelings of failure or frustration?	___	___	_____
5. Play with toy appropriate for his age?	___	___	_____

Comments:

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School performance	**Yes**	**No**	**Sometimes**
Does your child?			
1. Need to prop his head in his hand while reading/writing?	___	___	_____
2. Mix up which hand or foot is left or right?	___	___	_____
3. Know which hand is dominant?	___	___	_____
4. Make reversals of letters or numbers when writing?	___	___	_____
5. Read words in reverse?	___	___	_____
6. Find PE or sports to be a difficult experience?	___	___	_____
7. Have any learning problems?	___	___	_____

Describe:

Comments:

Has your child had any of the following examinations? If so, please give the approximate date, and examining person's name and phone number:

	Date	**Doctor**	**Phone**
1. Last physical examination:			
2. Neurology:			
3. Psychiatry:			
4. Psychology:			
5. Education:			
6. Speech or hearing:			
7. Other special exams:			

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My child's strengths are:

My Primary Concerns are:

Is there any other information, not asked in this form, that you would like to share about your child?

Patient: ______________________

Parent/Guardian Signature: ___________________________ Date: ____________

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