

Child's name: Height/Weight

Age: Date of Birth:

Male Female

Father's Name:

Mother's Name:

Date of Birth:

Date of Birth:

Address: City/Postal Code: Home phone: Cell: Father's email: Mother's email: Father's Occupation: Mother's Occupation: Living Situation: Married Single Divorced/Separated Other Siblings Name & Ages/Grades: Pet's & Names: What is the primary language spoken at home and by your child? May we leave messages relating to your child’s visits? YES NO

Primary Care Physician’s name: Contact Number:

What are your child's interests?

What are your child's activities at home and after school?

Does your family play board games and if so what are your child's favorite?

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**DEVELOPMENTAL HISTORY**

Please take your time when completing the following developmental history. Assessment of developmental history starts from pre-conception. This allows for identification of patterns and severity of symptoms when assessing your child. This information is intended to provide the most comprehensive care possible. This information will not be released without your written consent.

PERINATAL AND BIRTH HISTORY

Complicated Conception: Complicated Pregnancy:

 Yes

YES

 NO Explain:

NO Explain:

Complicated Birth? Explain:

Breast/Bottle fed & how long: Explain:

Weeks of development at birth:

FULL How many weeks pre-mature?

Child's weight and length at birth: Did child require oxygen? YES NO

Did child require feeding tube? Hospitalization required for child or mother? Has your child seen a neurologist?

 YES  YES YES

 NO  NO

NO MD:

Explain any other difficulties or special care

MEDICAL HISTORY

Diagnosis (es) since birth :

Has your child been tested for allergies? YES NO

Food Allergies: wheat gluten

eggs milk

peanuts none

other: \_ Has your child suffered any of the following and at what ages: High Fever; Pneumonia; Meningitis; Seizures; Chicken Pox; Headaches Foods/Dyes/Preservatives Sensitivities

Number of ear infections \_E\_a\_r\_t\_u\_b\_e\_p\_l\_a\_c\_e\_m\_e\_n\_t\_: Y\_E\_S N\_O

Surgical history 2

Vision problems: YES  NO YES  NO Explain:

Specialists seen since birth:

List medications your child is presently taking:

 \_ Last time hearing was tested Results: Other illnesses: Sleep patterns:

**PRESENT STATE OF FUNCTION**

Current Concerns/Age Concerns Developed:

Regression of skills/Explain

Is your child presently receiving therapy services?  YES  NO

If so which services: Physical Therapy Occupational Therapy Speech Therapy Behavior Therapy Early Intervention In-school therapy for: OT PT SLP ABA

Other: How often/where? Which school does your child attend?

 Private or Public, if private why:

Teacher Grade Is your child in resource/special education? YES NO Gifted Program:  YES  NO Does your child have the following: IEP 504 Accommodation plan

In Need of Support at school Concerns reported by Teacher/School:

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Are you content with your child’s progress at school?  YES  NO

Explain: Does you child have any identified learning delays or family history?

BEHAVIORAL/SENSORY CONCERNS

Attention concerns:

Does your child have difficulty socializing at school or in any other environment? YES NO Explain: Do you have concerns regarding your child’s speech?  YES  NO

Explain: How does s/he communicate wants/needs? Does s/he transition well from one environment/activity to another? YES NO

Does s/he exhibit any atypical behaviors i.e. flapping his hands, spinning, etc?

YES NO

Explain:

Does your child have frequent, significant tantrums?  YES  NO

Explain:

Does your child have difficulty with sudden and/or loud sounds?  YES  NO

Is your child a picky eater?  YES  NO Is your child sensitive to touch?  Yes No Eats a variety of textures? Knows when hands/face is dirty? Chews on objects/clothing Knows & uses personal space/boundaries? Willing to try new things? Does certain clothing/tags/shoes ect. bother your child or is the only one he/she will wear?

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1. Do you feel that your child met his/her developmental milestones on time when compared to peers or siblings?
2. Does your child appear to participate in age appropriate movement activities (i.e. jumping jacks, riding a bike, skipping, swimming, etc.)?
3. Do you have concerns or questions about his/her development?
4. When did your child gain bowel control? Bladder control?
5. Describe your child’s demeanor and behavior as an infant:
6. Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe:
7. Does your child resist having his/her teeth brushed, hair brushed, face washed, or nails trimmed?

Self Help Skills:

Fill in the applicable skill level (Independent or Needs Help) and any explanation for each skill: Toileting/wiping/flushing Bathing/showering Washes/rinses hair Brushing teeth Brushes/Combs hair

Dressing:

Underware Shirt/Dress Pants/Skirt Socks Shoes (takes on/off) Tying Shoes Buttons Snaps Zips/Unzips Jacket Dresses in a timely manner Feeding:

Use of cup & what kind Use of spoon Fork & knife Can carry a plate/bowl of food to and from the table Wipes face/hands when dirty Can sit through a meal/movie Are there any cultural or religious beliefs that you would like us to be aware of and/or take into consideration when we are working with your child PLEASE USE SPACE BELOW FOR FURTHER COMMENTS:

**OTHER QUESTIONS**

1. Is your child right or left handed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Can he/she catch/throw a ball?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Can he/she kick a ball?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Follows simple verbal directions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

a. 1-2 Steps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. 2-4 Steps\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. 4-6 Steps\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Recalls/follows basic household rules?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Recalls/follows morning/nighttime routines?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. Talks over others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. Can wait his/her turn or needs can be met?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. Know right/left, front/back, inside/outside?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Play Skills: independent parallel cooperative interactive typical

11. Is his/her play space/bedroom messy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Is his/her handwriting age appropriate?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 13. Is she/he age appropriate with scissors?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 14. how is her/his self confidence?\_\_\_ ~~\_~~\_\_\_ ~~\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_~~\_\_\_ ~~\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_~~\_\_\_ ~~\_\_\_~~  List any other concerns you may have that have not been addressed:

\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_ \_

What are the goals you would like to have your child reach during therapy?

\_1\_.

2.

3.

\_ What goals does your child have that can be addressed during therapy?

1.

2.

3.

What is your availability for therapy:

Mon Tues Wed Thur Fri

Signature Date

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