PEDIATRIC THERAPY SERVICES | where children learn and leap

DEVELOPMENTAL HISTORY

Child's Name:____DOB:____________________
Parent/Guardian Name:______________________________________Date:____________________

I. GENERAL INFORMATION

1. What is it about your child's development or medical condition that concerns you?_____
____
2. When was it first noticed?____
3. Does your child become impatient or frustrated?______________________________________
4. Describe any changes in your child's development within the past three months:
____
5. Describe your child's strengths:____
6. Describe your child's weaknesses:____
7. What are your goals for your child?____

II. MEDICAL HISTORY

1. <u>History of Pregnancy</u>
   A. Were there any problems with the pregnancy with this child (Rh incompatibility, toxemia, drug/alcohol abuse, exposure to infections/illness, unusual stress, etc.)?_______
   ____
   B. Mother's age at delivery:____
   C. Number of previous miscarriages:____

2. Labor and Delivery
   A. Full Term? Y N   If no, how early?__________   How late:__________
   B. Birth weight:___________   Weight at discharge:____________
   C. Apgar Scores:______________________
   D. Were there complications during delivery/labor? Please describe:_________________
   ____
   E. Check all that apply:

_______Cesarean Section | _______Breech | _______Face presentation
_______Transverse (sideways) | _______Transfusion | _______Cord around neck
_______Required a birth monitor | _______Seizures | _______Required forceps
_______Respirator-How long____ | _______Birth injuries | _______Feeding Difficulties
_______Jaundiced | _______Cried right away | _______Infections
_______Require exchange transfusion | | _______Heart defect

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F. Was your child in a regular or special care nursery?_____________How long?_________
G. Age at discharge?_________________
H. How was your child fed during hospitalization?______________________________
I. How is your child fed now?____
J. List any congenital abnormalities:____
K. Describe disposition/temperament (colic, sleep patterns, acceptance of being held)____
____

3. Medical History of Child
   A. Childhood Diseases: (check all that apply)
   ______Chicken Pox ______Measles ______Mumps
   ______Roseola ______Scarlet Fever ______Whooping Cough
   Any unusual problems:____
   B. Other Childhood Problems: (check all that apply)
   ______Allergies ______Asthma ______Feeding Problems
   ______Growth/weight problems ______Headaches/dizziness ______High Fevers
   ______Meningitis/encephalitis ______Persistent drooling ______Persistent vomiting
   ______Recurrent ear infec/tubes ______Recurrent colds ______Pneumonia
   ______Urine/bowel problems ______Seizures ______Sinusitis
   ______Vision problems ______Hearing problems ______Clumsiness
   Other:____

III. DEVELOPMENTAL HISTORY:

1. The approximate age your child achieved the following developmental milestones:
   Sat alone:________________ Crawled:___________ Hand preference:_________
   Walked:__________________ Toilet Trained:_______
2. Speech-Language Development (check all that apply)
   A. Did/does your child:
      __________Coo, babble, vocal play
      __________Imitate sounds, words or phrases
      __________Play peek-a-boo, pat-a-cake
      __________Imitate gestures (wave bye-bye, "so big")
      __________Use single works by 12-18 months
      __________Understand what you are saying
      __________Retrieve/point to common objects (ball, cup, body parts) upon request
      __________Follow simple directions (shut the door)
      __________Respond appropriately to yes/no questions
3. Gross Motor Development (check all that apply)
   A. Did/does your child:
   ______Lift head while on stomach ______bear weight on legs ______bear weight on arms
   ______Roll over ______pull self on tummy ______pull to sit

_______Sit alone _______stand holding on _______pull to stand
_______Creep on hand and knees _______stand alone _______walk
_______Throw ball overhand _______run _______walk up steps
_______Balance on each foot _______Jump _______Walk backward

4. Fine Motor/Sensory Development (check all that apply)

A. Did/does your child:

_______Follow with eyes to center _______follow with eyes past center
_______Hold rattle _______bring hand together
_______Reach for objects _______transfer objects from hand to hand
_______Hold object with thumb & finger _______scribble
_______Build tower with blocks _______copy shapes
_______Cut on a line/around a shape _______open/close buttons
_______Tie shoes _______open/close zippers

B. Did/does your child:

Sensory:

_______Have trouble falling asleep _______avoid being touched
_______Engage in self-stimulatory behaviors _______hear things most people tune out
_______React negatively to "normal" noises _______refuse to wear certain pcs clothing/textures
_______Fear of climbing _______is always in motion
_______Fall frequently _______dislike certain tastes
_______Dislike certain temperatures _______dislike certain textures

IV. FAMILY INFORMATION:

1. Does your child interact with other children on a regular basis? (siblings, daycare, school, babysitter, play group)

____

2. Behavior patterns: (check all that apply)

_______Interacts well with children/adults _______attentive
_______Cooperative _______tries new activities
_______Imitates actions/gestures/speech _______separation difficulties
_______Easily distracted/short attention _______easily frustrated/agitated
_______withdrawn _______poor eye contact
_______Dislike certain temperatures _______aggressive
_______Destructive _______withdrawn
_______Can play alone for reasonable length of time
_______Inappropriate behaviors: (please list)_______________________________________