DEVELOPMENTAL HISTORY FORM

Today's Date:____________________ Form Completed by:______________________________

Child's Name: ____

Birthdate: ________________ Age: ____________ Grade: ______________

School: ____

School Schedule: ____

Who referred you to our clinic?____

What is your child's doctor's name? ______________________________________

Medical Diagnosis: ____

Is your child receiving any other therapy services? _____________________________

____

Is your child participating in any social/community activities? ____________________

____

____

What are your child's favorite play interests? ________________________________

____

____

What are your primary concerns for your child?

Academic:____

____

Behavioral:____

____

Communication:____

____

Social:____

____

Sensory:____

____

Speech Development: ____

____

Gross Motor Skills: ____

____

Fine Motor Skills: ____

____

FAMILY MEMBERS:

	Occupation
Father____________________	_____________________________
Mother____________________	_____________________________

Marital status: Married _____ Separated: ______ Divorced: ______ Other:_________

		Age	Sex
Siblings	______________________	___	___
	______________________	___	___
	______________________	___	___

PREGNANCY:

	Yes	No	Comments:
Any complications/health problems?	___	___	____________________
Was bed rest recommended?	___	___	____________________
Any exposure to smoke, alcohol or environmental toxins?	___	___	____________________
Any medication(s) during pregnancy?	___	___	____________________
Was mother physically active?	___	___	____________________
Any emotional trauma or stress?	___	___	____________________

Any additional comments? ____

____

LABOR AND DELIVERY:

	Yes	No	Comments:
Was delivery at full term?	___	___	____________________
If not, gestational age			____________________
Vaginal Delivery	___	___	____________________
Induced labor?	___	___	____________________
Forcep or vacuum assist?	___	___	____________________
Caesarean birth?	___	___	____________________
Planned (Reason)	___	___	____________________
Emergency (Reason)	___	___	____________________
Delivery position? (e.g. breech)	___	___	____________________
Oxygen assist necessary?	___	___	____________________
Structural abnormalities noted at birth (cleft lip, torticollis, etc.)?	___	___	____________________

Birth weight? ______________________

APGAR Scores? ______________________

Any additional complications (i.e jaundice, difficulty feeding, weight loss, delayed discharge from the hospital):

____

____

ADOPTION: (if applicable)

Age when adopted? ____

Country adopted from? ____

Any known pregnancy and delivery information:______________________

____

Any known family health history: ______________________________

____

Is your child aware of adoption? ______________________________

INFANCY: (Please check all that apply)

Breast-fed ______ Bottle-fed ________ Difficulty feeding ________

Easy-going _____ Fussy, irritable ________ Colicky _________

Floppy _________ Tense muscles _________ Poor sleep patterns ______

Hard to console ________ Difficulty riding in a car seat ________

Pacifier/Thumb ________

What comforted your infant?

Swaddling ______ Rocking/Motion ______ Sucking/mouthing ________

Vibration ________ Other:____

Any additional comments: ____

____

CHILDHOOD HEALTH: (Please mark all that apply)

	Age	How Often
____Ear infections	________	___________
____Respiratory problems/asthma	________	___________
____Frequent colds	________	___________
____Strep throat	________	___________
____High fever	________	___________
____Seizures	________	___________
____Chronic stomachaches	________	___________
____Constipation	________	___________
____Limited food intake	________	___________
____Bedwetting	________	___________
____Difficulty falling asleep	________	___________
____Fitful Sleep	________	___________
____Skin Problems	________	___________
____Nail biting	________	___________
____Extended Thumb Sucking	________	___________
____Antibiotic use	________	___________

____Significant falls or injuries (describe) ________________________________

____Hospitalization (describe) ____

____Allergies (If yes, please list): ______________________________________

____Other: ____

____

Is your child in good general health at the present time?__________________________

____

How many hours of sleep does your child average at night? ____________________

What types of foods does your child like to eat at this time? ____________________

____

Do you find your child to be a picky eater or resistant of new textured foods? If yes, please describe. ____

____

Have you established a tooth brushing routine? Yes ____ No ____ How does your child respond? ____

Does your child drink from a cup? Yes ____ No ____

What type: sippy, straw, regular? ________________

Does your child cough when eating or drinking? Please describe. ____________________

____

Current medications: ____

Current dietary supplements: ____

Are immunizations up-to-date? ____

DEVELOPMENTAL TEAM:

Which of the following specialists has your child seen, or is currently seeing for an evaluation or treatment? **Please bring any current reports you may have.**

Specialist (Dr.'s name)	Doctor's name	Dates seen	Findings
Neurologist			
Psychologist			
Psychiatrist			
Speech Pathologist			
Audiologist			
Physical Therapist			
Occupational Therapist			
Developmental Optometrist			
Opthalmologist			
Nutritionist/Dietitian			
Allergist			
Gastroenterologist			