Date:

**Developmental History**

**Infant (up to age one)**

**Parents:** This history may appear to be quite long. However, a number of the questions require checking off responses which can be done quickly. This information is very useful in gaining a clear understanding of your child’s strengths and weaknesses. We appreciate your time.

**General Information**

Child’s Name:

 (first) (last) (nickname)

Birth Date: Phone #:
Address:

City/State/Zip:

Mother’s Name: Occupation:

Employer: Phone #:
Father’s Name: Occupation:
Employer: Phone #:

Names and ages of children in the home:

Emergency Contact Person (name, relationship, phone #):

Referred by (name, address, profession):

Does your child attend: □ Early Intervention Program/Daycare

If so,where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Physician (name, address, phone #):

**Medical Information**

Has your child received previous evaluation and/or treatment by an occupational therapist, physical

therapist or speech therapist? □Yes □ No

If yes, when and where:

Medical diagnosis (if any):

Has child had a vision test? □Yes □ No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has child had a hearing test? □ Yes □ No If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the results of hearing and vision tests?

Has your child had any of the following? If yes, describe and give approximate dates.

Childhood diseases or major illnesses:

Congenital abnormalities:

Surgery:

Serious injury:

Casts or braces:

Ear infections:

Tubes in ears:

Allergies:

Seizures:

Other:

List any medications your child is currently receiving and frequency of dosages:

Has your child received medications in the past for any of the above-mentioned conditions? □ Yes □ No If yes, what and when?

Are there any medical precautions the therapist should be aware of when working with your child?

□Yes □No

Does your child have any assistive devices (such as glasses, casts, or wheelchair)? □ Yes □ No

Has your child received other evaluations or treatment (psychological, speech and language, neurology)? □ Yes □ No If so, what type, when, and by whom?

 Type EvaI. Date Professional’s name Dates of therapy

What do you hope to gain from this evaluation and/or treatment?

**Mother’s Health during Pregnancy**

Did the mother:

1. have any infections/illnesses during pregnancy? □Yes □No
Describe:

2. use of alcohol or tobacco? □Yes □No

 Describe (amount/ frequency):

3. have any shocks or unusual stresses during pregnancy? □Yes □No
Describe:

4. receive any medication during pregnancy? □Yes □No
If yes, what kind:

5. have any complications during delivery/labor? □Yes □No
Describe:

**Child’s Birth**

Was or did child:

1. full term? □Yes □No Weight at birth: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

2. premature? □Yes □No Number of weeks:

3. small for gestational age (SGA)? □Yes □No

4. breech (feet first)? □Yes □No

5. require forceps for delivery? □Yes □No

6. require suction for delivery? □Yes □No

7. have any birth injuries? □Yes □No
Describe:

8. If known, Apgar score at one minute: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at five minutes:

9. require intensive-care hospitalization? □Yes □No How long?

10. jaundiced? □Yes □No Length of treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Infancy and Early Childhood**

Does or did your child:

1. have feeding problems? □Yes □No
If yes, describe:

. have sleeping problems? □Yes □No
If yes, describe:

3. have colic? □Yes □No For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. prefer certain positions as an infant? □Yes □No
If yes, describe:

5. dislike lying on stomach? □Yes □No

6. tolerate tummy time? □Yes □No If so, how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. dislike lying on back? □Yes □No

8. enjoy bouncing? □Yes □No

9. become calmed by car rides or infant swings? □Yes □No

10. become nauseated by car rides or infant swings? □Yes □No

**Developmental Milestones**

(Give approximate ages if remembered, or comment on anything unusual)

Rollover Walk Say words

Sit alone Chew solid food Say sentences

Crawl Drink from a cup

Was crawling phase brief? □Yes □No Absent? □Yes □No
Did child use a walker (rolling plastic seat)? □Yes □No How often?

 **SLEEP PATTERNS**

Does child:

1. have regular sleep patterns? □Yes □No If no, describe:

2. wake frequently during the night? □Yes □No If yes, describe:

3. tend to be an early riser, up and on the go? □Yes □No

4. have a difficult time falling asleep? □Yes □No

**PLAY SKILLS**

1. What are your child’s favorite play things?

2. What does the child do with these toys?

3. Who (people) does your child prefer to play with?

4. What activities does the child least enjoy?

5. Are there any things which your child tends to fear or avoid? □Yes □No

 If yes, describe:

6. How long does child play with one toy?

7. Does your child tend to play while in one position more than others? □Yes □No
 If yes, what position?

**Ease of Performance:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Developmental Skills****Can /does your child:** | **No** | **Yes** | **Some Difficulty** | **Average** | **Good** |
|  1. roll over? |   |   |   |   |   |
|  2. sit independently? |   |   |   |   |   |
|  3. crawl? |   |   |   |   |   |
|  4. pull to stand? |   |   |   |   |   |
|  5. stand with support? |   |   |   |   |   |
|  6. walk independently? |   |   |   |   |   |
|  7. grasp a rattle or small toy? |   |   |   |   |   |
|  8. use a raking motion to pick up small objects? |   |   |   |   |   |
|  9. pick up small items with fingers? |   |   |   |   |   |
| 10. transfer items from hand to hand? |   |   |   |   |   |
| 11. stack rings on a ring stand? |   |   |   |   |   |
| 12. stack blocks? |   |   |   |   |   |
| 13. drink from a bottle? |   |   |   |   |   |
| 14. drink from a sippy cup or cup? |   |   |   |   |   |
| 15. feed self finger foods? |   |   |   |   |   |
| 16. respond to name? |   |   |   |   |   |
| 17. respond to “no”? |  |  |  |  |  |
| 18. imitate/copy? |   |   |   |   |   |
| 19. like social play (peek-a-boo)? |   |   |   |   |   |

Has your child experienced any regression in skills or lost skills they had previously mastered?

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

What particular skills would you like your child to achieve in the next six months?

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

**Parental Concerns**

Please describe the major concerns you have regarding your child’s development (motor, sensory, emotional, speech) in order of importance to you.

1. (most important)

2.

3.

4.

5.

 Signature Date

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Published by Therapy Skill Builders” a division of The Psychological Corporation Il -800-228-0752 / ISBN 0761647759