

Speech, Physical, Occupational Therapy

**Pediatric Developmental History**

Child’s name: Date of birth:

Home address:

 (Include street number & name, city, state, & zip code)

Home phone: Primary phone:

**Family Information:**

Parent/Guardian: Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Include street number & name, city, state, & zip code)

Cell: Work: Email:

Parent/Guardian: Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Include street number & name, city, state, & zip code)

Cell: Work: Email:

Sibling’s name: Age:

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

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

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

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

Is there a family history of a speech/language, development, or physical impairment disorder?

Primary language spoken in the home:

Any other language spoken in the home? If yes, which language(s):

**Prenatal History:** please describe your pregnancy.

Normal: \_\_\_\_\_\_\_\_\_ Birth weight: \_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_ Full term: \_\_\_\_\_\_\_

Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment received by baby or mother:

**Postnatal History:** Please list and describe any important injuries, surgeries, or illnesses, including ear and chest infections. At what age did these occur?

Please list any current diagnoses your child may have and dates of diagnoses:

Diagnosis: Date:

**Milestones:** At what age did your child:

Turn head side to side:

Sit alone:

Life head while lying on tummy:

Crawl/Creep:

Pull to standing:

Roll over:

Cruise/walk with support:

Walk: Run:

Walk downstairs:

Climb stairs:

Drink from a cup:

Chew:

Feed self with spoon:

Babble: Say words:

Speak in phrases:

Play with other children:

Speak in sentences:

Potty train:

If your child needs assistance with the bathroom, do you give permission for the therapist to assist? (yes or no)

**Does your child:**  Yes No

|  |  |  |
| --- | --- | --- |
| Follow 1-step directions (ex: put your shoes on) |  |  |
| Follow 2-step directions (ex: get your cup and put it in the sink) |  |  |
| Point to common objects upon request (ex: where’s the ball, shoe, door) |  |  |
| Answer yes/no questions |  |  |
| Name a variety of common objects (ex: car, apple, dog, hat) |  |  |
| Speak clearly where others can understand him/her |  |  |
| Understand what you are saying |  |  |
| Repeat words, sounds phrases over and over |  |  |
| Participate in conversations with peers and adults |  |  |
| Answer simple who, what, where questions |  |  |

My child primarily communicates using:

\_\_\_\_\_gestures \_\_\_\_\_\_single words \_\_\_\_\_\_phrases \_\_\_\_\_\_ sentences

I understand what my child says \_\_\_\_\_\_% of the time.

Other family members understand what my child says \_\_\_\_\_% of the time.

Strangers understand what my child says \_\_\_\_\_\_% of the time.

Have you noticed any differences compared to other children?

Do you have any family/living problems which you think might affect your child’s development or therapy?

What does this child like?

What does this child dislike?

What are your primary areas of concern? What are you hoping for the Therapist to address?

What are your goals for Physical, Speech, or Occupational Therapy?

What other therapy and/or special education programs has your child had? What services is your child receiving now?

Is your child in daycare or school? Where?

**Please indicate with a plus (+) the items which you feel are strengths in this child and a minus (-) to identify those factors, which you feel, are weaknesses in this child.**

\_\_\_Response to smells and tastes

\_\_\_Response to family

\_\_\_Grooming

\_\_\_Response to touch

\_\_\_Response to visual stimuli

\_\_\_Response to sounds

\_\_\_Response to other children

\_\_\_Response to eating

\_\_\_General activity level

\_\_\_Self feeding

\_\_\_Dressing

\_\_\_Social skills

\_\_\_Attention span

\_\_\_Gross motor coordination

\_\_\_Response to movement

\_\_\_Motivation

\_\_\_Fine hand coordination

\_\_\_Ability to manage physical/motor requirements of play and school activities

\_\_\_Ability to manage thinking requirements of play and school activities

Does your child have glasses, hearing aids, braces, wheelchair, or other special equipment for daily activities?

Are there any allergies, seizures, or other medical conditions/problems that we should know about?

Does your child have a history of a swallowing disorder? If yes, please explain:

**Does your child:**

Use a bottle?

Cough and choke frequently?

Consume a variety of textures and tastes?

Is your child a picky eater?

Can your child feed himself/herself?­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any concerns you have with your child’s feeding skills and/or diet: \_\_\_\_\_\_\_\_\_

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

Is there anything else you would like us to know at this time that you feel can help us provide better services for your child?

Please list any motor development concerns you have (i.e., gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.):

**Academic History:** check off all that apply to your child:

\_\_\_\_Does well in school \_\_\_\_Is challenged by school

\_\_\_\_Does well with the exception of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Is challenged by reading \_\_\_\_Is not enrolled in school

\_\_\_\_Is an *A B C D F* student \_\_\_\_Is in a self-contained classroom

\_\_\_\_Receives resource/training for:

Please list any academic concerns you may have:

**Behavior/Social History:** check off all that apply to your child.

\_\_\_\_Is social and engaging \_\_\_\_Makes good eye contact with adults and peers

\_\_\_\_Is well behaved \_\_\_\_Plays well with other children

\_\_\_\_Pays attention \_\_\_\_Does well with change

\_\_\_\_Has tantrums \_\_\_\_Listens well \_\_\_\_Is extremely sensitive to criticism \_\_\_\_Plays well with other children

\_\_\_\_Is easy going \_\_\_\_Understands safety

\_\_\_\_Is aggressive \_\_\_\_Takes turns with peers

\_\_\_\_Is oppositional \_\_\_\_Unable to self-calm

\_\_\_\_Does not like new places/ people \_\_\_\_Does not like crowds

\_\_\_\_Has difficulty paying attention \_\_\_\_Has difficulty with transitions

Please list all current medications/prescriptions your child is taking:

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

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

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

Do we have your permission to take photographs of your child for evaluation and student training purposes? Yes No

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (please print): \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child: