

PEDIATRIC THERAPY SERVICES, INC.
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. History of Pregnancy
 - 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
 - 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 words 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:

- | | |
|---|---|
| <input type="checkbox"/> Have trouble falling asleep | <input type="checkbox"/> avoid being touched |
| <input type="checkbox"/> Engage in self-stimulatory behaviors | <input type="checkbox"/> hear things most people tune out |
| <input type="checkbox"/> React negatively to "normal" noises | <input type="checkbox"/> refuse to wear certain pcs clothing/textures |
| <input type="checkbox"/> Fear of climbing | <input type="checkbox"/> is always in motion |
| <input type="checkbox"/> Fall frequently | <input type="checkbox"/> dislike certain tastes |
| <input type="checkbox"/> Dislike certain temperatures | <input type="checkbox"/> 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)

- | | |
|---|---|
| <input type="checkbox"/> Interacts well with children/adults | <input type="checkbox"/> attentive |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> tries new activities |
| <input type="checkbox"/> Imitates actions/gestures/speech | <input type="checkbox"/> separation difficulties |
| <input type="checkbox"/> Easily distracted/short attention | <input type="checkbox"/> easily frustrated/agitated |
| <input type="checkbox"/> withdrawn | <input type="checkbox"/> poor eye contact |
| <input type="checkbox"/> Dislike certain temperatures | <input type="checkbox"/> aggressive |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> Can play alone for reasonable length of time | |
| <input type="checkbox"/> Inappropriate behaviors: (please list) | |
-