Background and Developmental History

Patient Name:	☐ M ☐ F	**DOB:**	**Age:**
Name of Person Completing Form:		**Today's Date:**	
Phone #:	**Alternate Phone #:**		
Address:			
City of Birth:	**Hospital:**		
Diagnosis *(if any) *please list diagnostic code if you know it.*			

Guardian #1:	☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Other: ________________________	
Name:		
Address:		
Home Phone #:	**Cell Phone #:**	**Business Phone #:**
E-mail Address:	**Occupation:**	
Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other: ________________________	
Religious Preference:		
Guardian #2:	☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Other: ________________________	
Name:		
Address:		
Home Phone #:	**Cell Phone #:**	**Business Phone #:**
E-mail Address:	**Occupation:**	
Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other: ________________________	
Religious Preference:		

Name and Ages of Child's Siblings			
Name:	**Age:**	**Name:**	**Age:**
Name:	**Age:**	**Name:**	**Age:**
Name:	**Age:**	**Name:**	**Age:**
Name:	**Age:**	**Name:**	**Age:**

REASON FOR REFERRAL/PRIMARY REASON FOR SEEKING THERAPY:
____
____
____
____

Please describe <u>your</u> vision for your child's individual educational & emotional needs:
____
____
____
____

MEDICAL HISTORY & BACKGROUND INFORMATION

Please check all that apply:

☐ born via C-section	☐ born vaginally	☐ full-term pregnancy
☐ premature explain/how many weeks?:________________ ____	☐ spent time in NICU explain:__________________________________ ____	☐ complicated pregnancy explain:__________________________________ ____
☐ uncomplicated pregnancy	☐ complicated delivery explain:__________________________________ ____	☐ uncomplicated delivery
☐ singleton birth	☐ twin birth	☐ triplet birth
☐ general health: good	☐ general health: fair	☐ general health: poor explain:__________________________________ ____
☐ history of NG tube feedings	☐ history of G tube feedings	☐ history of reflux
☐ Failure to Thrive	☐ history of pneumonia	☐ history of aspiration
☐ history of ear infections	☐ current PE tubes	☐ history of PE tubes
☐ history of breathing difficulties/respirator	☐ asthma	☐ food allergies
☐ history of measles	☐ history of chicken pox	☐ history of mumps
☐ history of scarlet fever	☐ history of tonsillitis	☐ history of meningitis
☐ history of strep throat	☐ tonsillectomy	☐ adenoidectomy
☐ diagnosis of ADHD/ADHD	☐ diagnosis of Autism	☐ diagnosis of Down's Syndrome
☐ seizure disorder	☐ other:	

Please explain any of the boxes checked above (i.e., age of incident, complications, etc)

Were any of these illnesses followed by changes in the child's typical behavior? Please explain.

Birth weight:

Please list your child's doctor(s):				
Pediatrician:		**NPI #:**		
Phone #:		**Fax #:**		
Specialists the child is followed by: (ex., Neurologist, Nutritionist, Allergist, etc.)				
Name:	**Specialty:**		**Phone #:**	
Name:	**Specialty:**		**Phone #:**	
Name:	**Specialty:**		**Phone #:**	

Name:	Specialty:		Phone #:	

PRIOR EDUCATION & TREATMENT INFORMATION

Has your child ever had speech, physical or occupational therapy prior to this evaluation? ☐ yes ☐ no

If yes, please check all that apply: ☐ speech therapy ☐ physical therapy ☐ occupational therapy

How long did your child receive therapy? **When did your child receive therapy**? **Where did your child receive therapy?**

_______________________________________ _______________________________________ _______________________________________

_______________________________________ _______________________________________ _______________________________________

SCHOOL/EDUCATION:

Is your child in school? ☐ yes ☐ no

If yes, what school? ____

What grade is he/she enrolled in? ____

Is he/she enrolled in:
☐ PPCD ☐ Special Education
☐ Head Start ☐ Other ________________

Has your child repeated a grade?
☐ yes ☐ no
If yes, which grade? ___________________________

What is your child's teacher's name? ____

What are your child's strengths and/or best subjects?

What are your child's most difficult problems in school?

Is your child on any medications?

Medication name:	How often does the child take the medication?	Why does the child take the medication? (allergies, ADHD, etc.)

VISION:

Does your child have any vision problems? ☐ yes ☐ no

Last vision screen (month/year) ________________

If yes, please explain _____________________________________

Results: ☐ normal ☐ abnormal ☐ other _______________

Where was your child's vision examined? ____________________

Does your child use glasses/contacts? ☐ yes ☐ no

HEARING:

Does your child have any hearing problems? ☐ yes ☐ no

Last hearing screen (month/year) ________________

If yes, please explain _____________________________________

Results: ☐ normal ☐ abnormal ☐ other _______________

Where was your child's hearing examined? __________________

Does your child use a hearing aid/cochlear implant?
☐ yes ☐ no

Does your child use any other adaptive equipment? ☐ yes ☐ no *If yes, please explain:* ____

DENTAL:

Does your child have any dental problems? ☐ yes ☐ no

Last dental cleaning (month/year) ____________

Results: ☐ normal ☐ abnormal ☐ other _______________

Please check all that apply for allergies:

☐ seasonal list: ________________ ☐ insects/animals list: ________________
☐ food list: ________________ ☐ other list: ________________
☐ medicine list: ________________

Surgeries/ Hospitalizations/ Visits to the Emergency Room

Month/Year	Reason	Length of Stay

DEVELOPMENTAL MILESTONES

At what age did your child first? *Please list an age next to each developmental milestone (in months or years)*				
Roll over	_____ months *or* _____ years	**Babble**	_____ months *or* _____ years
Sit up	_____ months *or* _____ years	**Say 1st word**	_____ months *or* _____ years
Crawl	_____ months *or* _____ years	**Combine 2 words phrases**	_____ months *or* _____ years
Stand Alone	_____ months *or* _____ years	**Sleep through the night**	_____ months *or* _____ years
Take first step	_____ months *or* _____ years	**Toilet trained**	_____ months *or* _____ years
Smile	_____ months *or* _____ years		

Primary languages spoken at home:	☐ English ☐ Spanish ☐ Mandarin ☐ Vietnamese ☐ French ☐ other_________________
the child is exposed to these languages by:	☐ mother ☐ father ☐ grandparents ☐ teacher ☐ nanny/babysitter ☐ other_________________

COMMUNICATION

Does your child? *Please mark all that apply*

☐ respond correctly to who, what, where, when, why, how questions?
☐ repeat sounds, words or phrases over and over?
☐ respond correctly to yes/no questions?
☐ retrieve or point to common objects upon request (ex. Ball, cup, shoes)?
☐ follow simple instructions (shut the door, get your shoes)?
☐ understand what you are saying?

Your child currently communicates using: *please mark any that apply.*

☐ body language *(ex., pointing or pulling you to what they want)*
☐ sounds (*vowels or grunting)*
☐ words *(ex., up, kitty, shoe)*
☐ 2 – 4 word sentences
☐sentences longer than 4 words
☐ other ____

FEEDING

Does your child have any feeding difficulties? ☐ yes ☐ no
Please Explain: ____

Has your child ever had a swallow study? ☐ yes ☐ no
If yes, date of last exam: ____________________ Location of exam: ______________________

Please check all that apply:

☐ choke or cough on foods or liquids?
☐ constant throat clearing?
☐ gagging?
☐ vomiting?
☐ frequent fevers or upper respiratory infections?
☐ wet/gurgly voice quality?
☐ picky eater?
☐ diet limited to less then 10 foods?
☐ significantly aversive to specific textures? *Please list* ____
☐ history of reflux?
☐ history of aspiration?
☐ history of tube feedings?

SENSORY PROCESSING

Please mark any that apply

Tactile Processing (Sense of Touch)

☐ bothered by clothing tags or textures
☐ refuses to wear shoes/socks
☐ avoids mess play (paint, dirt, sand, water, etc)
☐ difficulty tolerating haircuts, tooth brushing, nail trimming
☐ pulls away when touched
☐ unaware of pain or has high pain tolerance
☐ puts objects/clothing into mouth
☐ does not like having dirty hands

Auditory Processing (Hearing)

☐ covers ears at loud noises
☐ overly fidgets/tugs at clothing
☐ difficulty following directions
☐ appears to ignore name being called
☐ upset with vacuum, hairdryer, toilet, etc
☐ notices noises that are usually tuned out
☐ slow to respond to verbal cues
☐ distracted by background noises
☐ does not like noisy places

Visual Processing

☐ poor eye contact
☐ illegible handwriting
☐ likes to stare at spinning, shiny things
☐ difficulty copying from the board
☐ prefers being in the dark or avoids sunlight
☐ prefers fast paced tv shows

Proprioceptive Processing (Body Position)

☐ overly rough in play
☐ uses firm pressure when writing, drawing, or coloring
☐ bumps into others/pushes others
☐ enjoys crashing
☐ fatigues quickly
☐ appears clumsy
☐ jumps often
☐ prefers sedentary play
☐ slouches at desk

Vestibular Processing (Movement)

☐ frequently moving, "on the go"
☐ seeks out swinging, climbing more than others
☐ leans on others or objects for support when sit/stand
☐ loves spinning or does not get dizzy
☐ poor safety awareness
☐ loses balance easily
☐ afraid of heights
☐ avoids movement or fearful of movement
☐ dislikes head tipped back during bath, diaper change

Olfactory (Smell)

☐ smells everything
☐ bothered by smells others don't notice
☐ refuses food based on smell

Self-Regulation

☐ Difficulty with transitions/changes
☐ overly emotional/sensitive
☐ difficulty sleeping through the night
☐ inappropriate behaviors
explain: ___________________________
☐ poor frustration tolerance
☐ unwilling to try new activities
☐ Difficulty separating
☐ self-abusive behaviors
explain: ____________________________
☐ impulsive
☐ difficulty calming from tantrums
☐ aggressive
☐ frequent tantrums/meltdowns
explain: _______________________________________

Social Skills

☐ difficulty making or maintaining friendships
☐ does not respect personal space of others
☐ unable to interpret social cues
☐ withdrawn
☐ difficulty sharing/taking turns
☐ attends social outings (i.e., summer camp, birthday parties, family trips, spiritual gatherings)

DEVELOPMENTAL EVALUATIONS *has your child had any of the following evaluations?*			
Physchological/Neuropsychological	☐ yes ☐ no *If yes, please provide the following:* Please describe the result of the evaluation:	Name of Doctor: Location of Evaluation: Date:	
Occupational Therapy	☐ yes ☐ no *If yes, please provide the following:* Please describe the result of the evaluation:	Name of Evaluator: Location of Evaluation: Date:	
Physical Therapy	☐ yes ☐ no *If yes, please provide the following:* Please describe the result of the evaluation:	Name of Evaluator: Location of Evaluation: Date:	
Speech and Language	☐ yes ☐ no	Name of Evaluator:	

	If yes, please provide the following:	Location of Evaluation: Date:	
	Please describe the result of the evaluation:		
Developmental Evaluation	☐ yes ☐ no *If yes, please provide the following:*	Name of Evaluator: Location of Evaluation: Date:	
	Please describe the result of the evaluation:		
Neurological Evaluation	☐ yes ☐ no *If yes, please provide the following:*	Name of Evaluator: Location of Evaluation: Date:	
	Please describe the result of the evaluation:		

ADDITIONAL INFORMATION:		
What are your child's most enjoyable activities?		
What frightens your child?		
What do you do to comfort your child?		
What is your child's sleeping/napping schedule?		
Is your child aware of or frustrated by, any communication difficulties?		
Is your child aware of, or frustrated by, any physical difficulties?		
Does your child have any duties at home? ☐ yes ☐ no *If yes, please describe:		
List the places that your child frequently visits:		
List the important people in your child's life and what he/she calls them:		
What do you see as your child's most difficult problem at home?		
Do you feel your child is developing at the same rate as his/her peers (socially, lay skills, self-help skills, etc.)? ☐ yes ☐ no *If no, please explain.		
PLAY SKILLS: please mark any that apply		
☐ bangs items/head	☐ mouths objects	☐ stacks blocks
☐ manipulates knobs/buttons	☐ pretends to sleep	☐ feeds doll, stuffed animal, etc.
☐ moves toy car with appropriate sound of vehicle	☐ combines ideas (ex., drives car & crashes it, feeds dog & puts it to bed)	☐ plays our scenarios, 3-4 steps (ex., set table, pretends to cook food, eats food)
SCHEDULE: Please describe a 24-hour time period for your child (i.e., from the time they wake up, until they go to bed, including daily routines & ho well they do/do not sleep).		