849 Menlo Ave. Menlo Park, CA 94025
Phone: 650-323-0805
Fax: 650-323-5262
www.play-steps.com
Theresa Baumert, OTR/L, Director

Pediatric OT Developmental History Questionnaire

Child's Name ______________________ Birthdate __________

Prenatal and Birth History:

Any complications during pregnancy or birth? Any medical interventions? Please describe.

____
____
____

Medical History:

Has your child had any significant illnesses or injuries? Please describe. __________

____
____
____

	Yes	No
Has your child had frequent ear infections?	____	____
Does your child respond consistently to sound?	____	____
Has your child's vision been tested?	____	____
If yes, please note results ______________________		
Does your child have allergies?	____	____
If yes, please note what he/she is allergic to ______________		
Has your child had any seizures or periods of unconsciousness?	____	____
If yes, please add details ______________________		
Any current medications?	____	____
If yes, please note medication and purpose ______________		

Pediatrician and phone number: ______________________

Motor Development

Age sat unsupported ____ Age fed self ______ Age pedaled trike ____
Age crawled ______ Age dressed self ____ Age rode bike ____
Age walked ______ Age toilet trained ____ Age tied shoes ____
Does your child seem clumsy or poorly coordinated? ______________

____

Poor suck in infancy? ____ Drooling after 2 ½ years? ____ Difficulty chewing? ____
Any current problems with self-care? ______________________
Does your child independently manage buttons? ____ snaps? ____ zippers? ____
Does your child hold eating utensils appropriately for his/her age? __________
Cut food independently with a table knife? ____ Hold a pencil appropriately? ____
Handedness: Hand used for writing? ____ Drawing? ____ Brushing teeth? ____
Eating with a fork? ____ Cutting with scissors? ____ Throwing a ball? ____
Age at which hand preference was consistent? ______________________
Additional comments about motor development? ______________________

____

____
____
____
____

Language Development

Age spoke first word _______ Age put 2-3 words together ________ Articulation ok? ________
Additional comments about speech/language development? ______________________________
____
____

Behavioral Characteristics

Does your child get along well with other children? ___________________________________
Does your child get along well with adults? ____

Is your child ...?	Yes	No	Comments
Shy?	_____	_____	______________________________
More active than others?	_____	_____	______________________________
Impulsive	_____	_____	______________________________
Wiggly when seated	_____	_____	______________________________
Easily distracted	_____	_____	______________________________
Socially engaged	_____	_____	______________________________
Interested in learning	_____	_____	______________________________
Does your child ...?			
Have difficulty sleeping	_____	_____	______________________________
Have a limited food repertoire	_____	_____	______________________________
Avoid certain food textures	_____	_____	______________________________
Suck his/her thumb	_____	_____	______________________________
Chew on non-food objects	_____	_____	______________________________
Avoid some clothing textures	_____	_____	______________________________
Avoid getting hands messy	_____	_____	______________________________
Touch objects/people frequently	_____	_____	______________________________
Easily become dizzy or carsick	_____	_____	______________________________
Enjoy fast-moving rides	_____	_____	______________________________
Object to certain sounds	_____	_____	______________________________
Object to bright lights	_____	_____	______________________________

Please add any other behavioral characteristics or observations ______________________
____
____
____
____
____

What are your child's favorite activities? _____________________________________
____
____
____
____
____

What things does your child tend to fear or avoid? ______________________________
____
____
____

Educational History

Has your child attended preschool? If so, please note which school, dates of attendance, and any concerns raised by the school. ______

Has your child attended kindergarten? If so please note which school, dates of attendance, and any concerns raised by the school. ______

Please note elementary school(s) attended, and any concerns raised by the school(s). ______

Does your child like school? ______

Does your child have an IEP? Any special services provided at school? ______

Has the school recommended any private services for your child? ______

Has your child participated in any evaluations outside of school, with private therapists or agencies? If yes, please summarize the results, and note dates services were provided and by whom. ______

Has your child participated in tutoring or therapy services outside of school, with private tutors/therapists or private agencies? If so, please note services provided, when, and by whom.

______

General

Is English the only language spoken at home? If not, what other language(s) are used? ______

Do any family members have a history of learning differences, speech/language difficulties, coordination difficulties, or emotional difficulties? If so, please describe. ______

Please add any other comments that may be relevant for planning your child's evaluation or therapy. ______

Parent Signature ______ Date ______