Developmental History

Child's Name: _____ DOB: _____ Age: _____ Today's Date: _____
Name of Parent/Guardian completing questionnaire: _____
Relationship to Child: _____
Mother's Name: _____ Father's Name: _____
Current School: _____ Current Grade: _____
Does your child have an IEP or 504 Plan? _____ If so, what services is s/he receiving or what accommodations are in place? _____
_____
Please list any diagnoses that your child has been given by other professionals working with him/her:
_____
Will you be submitting your invoices to an insurance company for reimbursement? _____
If yes, please provide insurance company information: _____
_____

Prenatal History:
Please describe the pregnancy: _____
Duration of pregnancy: _____ Type of delivery: _____
Any birth complications: _____
Treatment received by mother or baby: _____
Weight at birth: _____ Length at birth: _____
If your child was adopted, do you have any information about the birth mother's health and pregnancy?
_____

Postnatal History:
Please list and describe any important injuries, illnesses, surgeries or hospitalizations and at what ages they occurred: _____
_____
_____
How many ear infections? _____ Describe treatment: _____
If your child has received any antibiotics, have they been provided with follow-up probiotics? _____
Milestones:
At what age did your child?: Lift head while lying on tummy: _____ Roll over: _____
Sit alone: _____ Crawl: _____ Pull to standing: _____ Walk with support: _____
Walk alone: _____ Drink from a cup: _____ Feed self with a spoon: _____
Speak single words: _____ Speak phrases: _____ Speak sentences: _____
Please list the names and ages of any siblings: _____
_____
Have you noticed any differences in the development of your child compared to your other children or your child's peers? _____
_____
Do you have any family/living problems which you think might affect your child's development or therapy?
_____

What are your child's favorite hobbies, activities, sports, school subjects? _____

_____

When alone, how does your child like to spend time? _____

_____

What does your child dislike doing? _____

_____

What do you enjoy doing with your child? _____

_____

What do you consider to be your child's strengths? _____

_____

What are your main areas of concern for your child? _____

_____

What goals would you like to see achieved as a result of your child receiving occupational therapy?

_____

_____

Please list any therapies that your child has received in the past or is receiving now. Include type of therapy, dates and location/program/clinic name.

_____

_____

_____

_____

Please indicate with a plus (+) the skills which you feel are strengths for your child and with a minus (-) the skills which you feel are challenging for your child:

_____ Response to smells
_____ Response to tastes
_____ Response to sounds
_____ Response to touch
_____ Response to movement
_____ Response to visual stimuli
_____ Listening/Auditory Processing
_____ Following directions
_____ Gross-motor coordination
_____ Attention span
_____ Self-feeding
_____ Dressing
_____ Motivation
_____ Response to other children
_____ Eating/diet
_____ Speaking
_____ Communicating with peers
_____ Communicating with family
_____ Imaginative play
_____ Completing puzzles
_____ Drawing/writing
_____ Fine-hand coordination
_____ General activity level
_____ Toileting
_____ Grooming
_____ Response to Family
_____ Ability to manage physical/motor requirements of play/school activities
_____ Ability to manage cognitive requirements of play/school activities

Do you know your child's dominance profile?

Hand	R	L
Foot	R	L
Eye	R	L
Ear	R	L
Brain Hemisphere	R	L

Please circle or list any special equipment your child requires (corrective lenses, hearing aid/cochlear implant, braces, orthotics, wheelchair) _____

_____

Please list any allergies your child has: _____

_____

Does your child follow any special diets or have any nutritional restrictions? _____

_____

Please list any medications your child is currently taking (including frequency and dosage):

_____

_____

Please circle or list any medical issues that your child has (seizures, asthma): _____

_____

_____

Does your child have any bedtime challenges? (getting to bed, falling asleep, staying asleep, bedwetting, nightmares): _____

_____

Does your child have any specific fears that cause distress? _____

_____

Does your child have any eating problems? (resistant eater, limited diet):_____

_____

Is there any history of psychological diagnoses, learning differences or sensory processing differences in your child's extended family? _____

_____

Did any family members have challenges similar to your child's when they were a child? _____

_____

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

_____

_____