



Today's Date _____

Client's Name: _____ first _____ last _____ _____ nickname _____
Parent(s)' Names: _____
Birth Date: _____ Age: _____ M / F

Dear Parent, Guardian or Adult Client,

Please share with us what you hope to gain from this evaluation, therapy or consultation:

Developmental History

Adolescent and Adult

Thank you for taking the time to fill out this history. The valuable information you share about your child's struggles, accomplishments, and the goals you hope they will achieve assists us in developing a comprehensive assessment and intervention plan.

Previous Testing

Please list professionals that have done evaluations and/or treatment with your child and circle the letter for the type of service they provided:

Name: _____ Prof: _____ E / T

Name: _____ Prof: _____ E / T

Name: _____ Prof: _____ E / T

Medical History:

Please indicate if you have or have had any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Anxiety or Mood Disorder |
| <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Visual or Ocular-Motor Problems | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Non-Verbal Learning Disability | <input type="checkbox"/> Cognitive Delays |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other Learning Disabilities | <input type="checkbox"/> Developmental Delays |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Fragile X Syndrome |
| <input type="checkbox"/> Congenital Anomalies | <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Braces/Assistive Devices | <input type="checkbox"/> Obsessive-Compulsive Disorder | <input type="checkbox"/> Other: _____ |

Would you describe and clarify the above information so that we may better understand how to work with you (e.g. medical precautions, physical limitations, behavioral style, learning style):

Do you currently take any medications?

Med: _____ Frequency: _____ Purpose: _____

Med: _____ Frequency: _____ Purpose: _____

Med: _____ Frequency: _____ Purpose: _____

Med: _____ Frequency: _____ Purpose: _____

Birth History:

Are you adopted or in foster care? Y / N If 'Y' please specify: _____

Did the mother have any of the following difficulties during pregnancy?

- | | | |
|--|---|---|
| <input type="checkbox"/> Infections | <input type="checkbox"/> Spotting/ Bleeding | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Significant Illness | <input type="checkbox"/> Shocks or Unusual Stresses | <input type="checkbox"/> Mandatory Bed Rest |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Premature Labor | <input type="checkbox"/> Other: _____ |

Would you please elaborate on the complications during pregnancy (e.g. medications needed, complications during labor and delivery):

Did you have any of the following complications during and after delivery?

- | | | |
|---|--|---|
| <input type="checkbox"/> Premature (# of Wks) _____ | <input type="checkbox"/> Meconium Aspiration | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Breech | <input type="checkbox"/> Forceps Delivery | <input type="checkbox"/> Apnea |
| <input type="checkbox"/> Cord Wrap | <input type="checkbox"/> Suction Delivery | <input type="checkbox"/> Birth Injuries |
| <input type="checkbox"/> Heart Rate Drop | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Other: _____ |

Please elaborate on these difficulties and how they were resolved (e.g. medications, procedures, ICU):

Developmental History

As a baby did you experience any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficulty w/ breast feeding | <input type="checkbox"/> Not calmed by cuddling | <input type="checkbox"/> Startled when approached |
| <input type="checkbox"/> Difficulty w/ bottle feeding | <input type="checkbox"/> Trouble settling to sleep | <input type="checkbox"/> Strong startle with noises |
| <input type="checkbox"/> Difficulty w/ baby food | <input type="checkbox"/> Resistance to lying on belly | <input type="checkbox"/> Cried when lifted in the air |
| <input type="checkbox"/> Difficulty eating soft solids | <input type="checkbox"/> Difficulty engaging socially | <input type="checkbox"/> Cried w/ head tipped back |
| <input type="checkbox"/> Colic (# of Mths) _____ | <input type="checkbox"/> Inconsolable crying | <input type="checkbox"/> Other: _____ |

What were the strategies that worked best to calm and settle you as a child?

As well as you can remember please tell us when you achieved the following developmental milestones: (Leave it blank if you are unsure and put N/A if they are not yet achieved):

Smiled _____	Slept Through Night _____	Said Words _____
Rolled Over _____	Fell Asleep Alone _____	Spoke Sentences _____
Sat Alone _____	Stood Independently _____	Toilet for Urine _____
Crawled _____	Walked _____	Toilet for BM _____

For the following list of functional skills please check the box that best describes your current performance. Feel free to cross out anything that is not applicable and comment on multiple items:

Can you:	Unable	With Difficulty	Accomplished	Done Easily
Manipulate closures (zippers, snaps and buttons)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tie shoes/ Tie a man's tie?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blow dry hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use a razor for shaving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use dental floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blow nose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall asleep easily and sleep throughout the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open snacks and sodas or soft drinks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow written directions (e.g. cooking recipes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blow up a balloon/ Blow bubbles with gum?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open and close an umbrella?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cut with scissors/ Cut with a knife?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use a blender/ Use a coffee maker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touch type accurately on a computer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catch a ball/ Kick a ball?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ride a bicycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safely cross the street?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow steps for aerobics, karate or gym activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swim using the crawl or other strokes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back a car up straight/ Parallel park a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Please comment on any concerns you have about your development:

Are you experiencing difficulties with daily activities? (e.g. dressing, eating, bed time routines, getting ready for school, going to the store or a restaurant, participating in social activities):

Please describe any strategies or supports that help you with daily routines and activities:

Please tell us about your gifts and strengths:

What would you like to achieve?

Social Development:

Please check any of the following items that pertain to or describe you. Feel free to add comments:

- | | |
|---|---|
| <input type="checkbox"/> Make friends easily | <input type="checkbox"/> Tend to be impulsive |
| <input type="checkbox"/> Prefer to be alone | <input type="checkbox"/> Tend to be cautious |
| <input type="checkbox"/> Prefer to be with others | <input type="checkbox"/> Are more often quiet and withdrawn |
| <input type="checkbox"/> Have trouble getting along with peers | <input type="checkbox"/> Are more often active and intense |
| <input type="checkbox"/> Prefer to sit back and let others lead | <input type="checkbox"/> Have anxiety or panic attacks |
| <input type="checkbox"/> Tend to be bossy or pushy | <input type="checkbox"/> Feel discouraged or depressed |
| <input type="checkbox"/> Get easily frustrated | <input type="checkbox"/> Have trouble making needs known |
| <input type="checkbox"/> Lack self confidence | <input type="checkbox"/> Tend to be very set in your routines |
| <input type="checkbox"/> Have strong outbursts of anger | <input type="checkbox"/> Have fear of leaving house |

Sensory History:

Please circle the number that best describes you. The scale below can be used for reference. Feel free to cross out parts of any questions that do not apply. We also appreciate your descriptive comments to give us a better sense of the specific areas of difficulty you are or have experienced in the past.

Scale: 5 = Always 4 = Frequently 3 = Sometimes 2 = Rarely 1 = Never

Visual:

Do you:

Additional Comments

Become easily distracted by visual stimulation?	5	4	3	2	1	
Get overwhelmed or disorganized by too much information on a page?	5	4	3	2	1	
Blink or become irritated by bright lights or moving objects?	5	4	3	2	1	
Ever seek out dark, quiet, or small places to when feeling bothered?	5	4	3	2	1	
Become active or grouchy after watching TV or playing on computer?	5	4	3	2	1	
Avoid, or have difficulty with eye contact?	5	4	3	2	1	
Seek visual stimulation through flicking or spinning objects?	5	4	3	2	1	
Have difficulty looking for items on a grocery shelf?	5	4	3	2	1	
Have trouble finding something in a cluttered drawer or bag?	5	4	3	2	1	
Avoid, or get frustrated with puzzles, mazes or hidden pictures?	5	4	3	2	1	
Have difficulty copying down information?	5	4	3	2	1	
Have difficulty following traffic signs while driving?	5	4	3	2	1	
Struggle with finding your way from one place to another?	5	4	3	2	1	
Have difficulty discerning facial expressions or body language?	5	4	3	2	1	
Have difficulty finding a familiar face in a crowd?	5	4	3	2	1	

Auditory:

Do you:

Additional Comments

Become distracted by background noises (e.g. fan, refrigerator)?	5	4	3	2	1	
Feel overly sensitive to certain noises? (Please specify)	5	4	3	2	1	
Negatively react to noisy, chaotic situations?	5	4	3	2	1	
Talk loudly or play music and TV on loud volume?	5	4	3	2	1	
Have difficulty correctly identifying sounds?	5	4	3	2	1	
Have trouble understanding words to a song or what an announcer says?	5	4	3	2	1	
Have trouble following 2-3 step verbal directions (given at once)	5	4	3	2	1	

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Smell and Taste:

Do you:

Additional Comments

Feel overly sensitive to certain smells? (Please specify)	5 4 3 2 1	
React defensively to the taste and textures of foods (please specify)	5 4 3 2 1	
Have a limited food repertoire? (Please list foods & flavors you eat)	5 4 3 2 1	
Tend to explore through smell; deliberately smells objects?	5 4 3 2 1	
Lick, suck, mouth or chew on non-food items? (Please specify)	5 4 3 2 1	
Lack awareness in and around your mouth (e.g. messy eater)?	5 4 3 2 1	

Touch:

Do you:

Additional Comments

Feel overly sensitive to tags or seams in clothes?	5 4 3 2 1	
Strongly dislike haircutting or shampooing?	5 4 3 2 1	
Dislike fingernail or toenail cutting, or feel it hurts?	5 4 3 2 1	
Have a strong preference for temperature of water and foods?	5 4 3 2 1	
Avoid touching textured mediums (e.g. hair products, raw meat, sand)?	5 4 3 2 1	
Feel bothered by clothes: need to pull at, adjust, or remove them?	5 4 3 2 1	
Have strong clothing preferences? (Please describe)	5 4 3 2 1	
React strongly to being touched unexpectedly?	5 4 3 2 1	
Feel discomfort with, or avoid having people close to you?	5 4 3 2 1	
Become overly irritated when splashed with water?	5 4 3 2 1	
Tend to be more sensitive to pain than others?	5 4 3 2 1	
Crave pressure (e.g. hugs, tight clothes, heavy blankets, pillows)?	5 4 3 2 1	
Ever pinch, bite, or otherwise hurt self? (Please specify)	5 4 3 2 1	
Feel the need to handle and touch objects thoroughly?	5 4 3 2 1	
Frequently drop items if not watching hands?	5 4 3 2 1	
Have awkward control with hands; feel like you are wearing gloves?	5 4 3 2 1	
Have difficulty finding objects in your pocket or purse without looking?	5 4 3 2 1	
Tend not to feel pain as much as others?	5 4 3 2 1	

Scale: 5 = Always 4 = Frequently 3 = Sometimes 2 = Rarely 1 = Never

Body Awareness:

Do you:

Additional Comments

Get over stimulated with negotiating through crowds of people?	5	4	3	2	1	
Seek 'heavy work' such as cleaning, jumping or pushing heavy objects?	5	4	3	2	1	
Seek input to mouth through chewy, crunchy foods or stuffing mouth?	5	4	3	2	1	
Find physical activity organizing when overloaded or irritated?	5	4	3	2	1	
Tend to bump or push others either by accident or on purpose? (Specify)	5	4	3	2	1	
Not understand personal space and often get too close to others?	5	4	3	2	1	
Have trouble judging body movement in space; frequently bump into things?	5	4	3	2	1	
Have difficulty grading amount of force (in hugs, writing, petting cat)?	5	4	3	2	1	
Grasp objects too tightly; or spill and break things more than expected?	5	4	3	2	1	

Movement:

Do you:

Additional Comments

Frequently experience motion sickness in cars, trains, boats, etc.?	5	4	3	2	1	
Feel fearful of, or avoid swings and amusement park rides?	5	4	3	2	1	
Hesitate or avoid climbing or going down stairs, ladders, ramps, bridges?	5	4	3	2	1	
Become upset with head motion (e.g. lying backward, moving elevator)?	5	4	3	2	1	
Dislike escalators, elevators, or going through tunnels? (Please specify)	5	4	3	2	1	
Become disoriented easily or feel disconnected from gravity?	5	4	3	2	1	
Feel most happy when engaged in movement activities?	5	4	3	2	1	
Seek strong movement through spinning, rocking, head banging, etc.?	5	4	3	2	1	
Feel the need to be in constant motion, have trouble sitting still?	5	4	3	2	1	
Enjoy being upside down with head in an inverted position?	5	4	3	2	1	
Have difficulties with activities requiring balance (e.g. bike riding)?	5	4	3	2	1	
Fall when a bus or subway stops quickly?	5	4	3	2	1	
Fall or trip more often than others your age?						
Have difficulty discriminating the speed and direction of movement?	5	4	3	2	1	
Feel surprised when you fall (e.g. unexpectedly falling out of chair)?	5	4	3	2	1	
Have trouble driving a car (e.g. going straight, turning corners, merging)	5	4	3	2	1	

Scale: 5 = Always 4 = Frequently 3 = Sometimes 2 = Rarely 1 = Never

Motor Coordination:

Do you:

Additional Comments

Have articulation difficulties making it hard to understand you?	5 4 3 2 1	
Keep mouth open most of the time or chew with mouth open?	5 4 3 2 1	
Have an awkward grasp with a pencil or pen?	5 4 3 2 1	
Find small manipulative/ fine motor activities difficult?	5 4 3 2 1	
Struggle, easily fatigue or have difficulty with handwriting?	5 4 3 2 1	
Grimace or move tongue while doing fine motor tasks?	5 4 3 2 1	
Seem weaker than other people your age?	5 4 3 2 1	
Tend to fatigue easily with physical activity (Poor endurance)?	5 4 3 2 1	
Slump, stand or move in and out of the chair while doing work?	5 4 3 2 1	
Take a long time to do most motor tasks?	5 4 3 2 1	
Feel reluctant to participate in sports and games?	5 4 3 2 1	
Have difficulty copying or maintaining rhythms?	5 4 3 2 1	
Take longer than other people to learn and master new motor tasks?	5 4 3 2 1	
Have difficulty planning a dinner or packing for a vacation?		
Struggle with motor tasks that have several steps?	5 4 3 2 1	
Feel inconsistent in motor skills (e.g. can do it one day, but not next?)	5 4 3 2 1	

School/ Work Performance:

Please check off any areas that you feel you struggle with in school and at work:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sitting still | <input type="checkbox"/> Finishing work | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Paying attention | <input type="checkbox"/> Social interactions | <input type="checkbox"/> Writing/ Spelling |
| <input type="checkbox"/> Following directions | <input type="checkbox"/> Following the rules | <input type="checkbox"/> Math |
| <input type="checkbox"/> Working independently | <input type="checkbox"/> Group activities/ meetings | <input type="checkbox"/> Tool use |
| <input type="checkbox"/> Organizing work | <input type="checkbox"/> Unscheduled, unexpected events | <input type="checkbox"/> Other: _____ |

What extracurricular activities do you participate in?

Signature of Person(s) Completing Form: _____

Relationship to Client: _____