South Shore
THERAPIES

DEVELOPMENTAL HISTORY *Ages 4-14 years*

Child's Name: _____ _____
first **last**

_____
nickname

Birth Date: _____ **Age:** _____ **M / F**

Child's School: _____ **Current Grade:** _____

Teacher(s): _____ **Type of Class: Typical/Integrated/Separate**

Pediatrician: _____ **Classroom Assistance (if any):** _____

Parent One: _____ **Profession:** _____

Address: _____

_____

Home Phone: _____ **Cell Phone:** _____

Parent Two: _____ **Profession:** _____

Address (If different than above):_____

_____

Home Phone: _____ **Cell Phone:** _____

Marital Status: **Married** **Single** **Divorced** **Other:** _____

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

_____

_____

_____

_____

Signature of Person(s) Completing Form: _____

Relationship to Client: _____

DEVELOPMENTAL HISTORY *Ages 4-14 years*

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

MEDICAL HISTORY

Please indicate if your child has or has had any of the following:

- ❑ High Birth Weight
- ❑ Low Birth Weight
- ❑ Viral Infections
- ❑ Strep Infections
- ❑ Ear Infections
- ❑ Ear Tubes
- ❑ Allergies
- ❑ Gastrointestinal Issues
- ❑ Asthma
- ❑ Diabetes
- ❑ Seizures
- ❑ Hearing Loss
- ❑ Visual or Ocular-Motor Problems
- ❑ Cerebral Palsy
- ❑ Non-Verbal Learning Disability
- ❑ Other Learning Disabilities
- ❑ Asperger's Syndrome
- ❑ Autism Spectrum Disorder
- ❑ Obsessive-Compulsive Disorder
- ❑ Anxiety or Mood Disorder
- ❑ Tourette's Syndrome
- ❑ ADD/ADHD
- ❑ Cognitive Delays
- ❑ Developmental Delays
- ❑ Congenital Anomalies
- ❑ Fragile X Syndrome
- ❑ Muscular Dystrophy
- ❑ Mitochondrial Disease
- ❑ Braces/Assistive Devices
- ❑ Other:

Is your child up to date on his/her vaccinations? ❑ Yes ❑ No

Please describe any medical precautions, physical limitations, or relevant information about your child's medical history that may help us better understand how to work with your child. (i.e. allergies, seizure protocol, inhaler, dietary restrictions)

_____

_____

_____

_____

Does your child currently take any medications or supplements (e.g. melatonin, fish oil)?

Med: _____ Frequency: _____ Purpose: _____

Med: _____ Frequency: _____ Purpose: _____

Med: _____ Frequency: _____ Purpose: _____

Supplement: _____ Frequency: _____ Purpose: _____

Supplement: _____ Frequency: _____ Purpose: _____

PREVIOUS TESTING

Please list professionals that have done evaluations (E) and/or treatment (T) with your child and circle the letter for the type of service they provided (e.g. EI, PT, OT, Speech, Developmental Pediatrician, Nutritionist, Eye Doctor):

Name: _____ Prof: _____ E /T

Name: _____ Prof: _____ E /T

Name: _____ Prof: _____ E /T

Name: _____ Prof: _____ E /T

Name: _____ Prof: _____ E /T

BIRTH HISTORY

Is your child adopted? ❑ No ❑ Yes

If Yes, please specify the birth country: _____ Age adopted: _____

Is the child with you in foster care? ❑ No ❑ Yes

Is you child part of a multiple pregnancy? ❑ No ❑ Yes: ❑ Twins ❑ Triplets ❑ Other: _____

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

- ❑ Infections
- ❑ Significant Illness
- ❑ High Blood Pressure
- ❑ Spotting/ Bleeding
- ❑ Shocks or Unusual Stresses
- ❑ Premature Labor
- ❑ Prolonged Labor
- ❑ Gestational Diabetes
- ❑ Mandatory Bed Rest

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

_____

_____

Birth Weight: _____ Apgar Scores: _____

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

- ❑ Premature (# of Wks) _____
- ❑ Breech
- ❑ Cord Wrap
- ❑ Fetal Distress
- ❑ Meconium Aspiration
- ❑ Forceps Delivery
- ❑ Suction Delivery
- ❑ Cesarean Section
- ❑ Jaundice
- ❑ Apnea
- ❑ Birth Injuries
- ❑ Other:

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

_____

_____

DEVELOPMENT

As a baby did your child experience any of the following:

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

Please comment on any past stressful events: _____

_____

As well as you can remember, please tell us when your child achieved the following developmental milestones:
(Leave it ***blank*** if you are unsure, put ***N/A*** if they are not yet achieved, or ***X*** if they did not occur):

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

Please comment on any concerns you have about your child's development: _____

_____

_____

Please tell us about your child's gifts and strengths: _____

_____

SPEECH AND LANGUAGE HISTORY

Please indicate all means of communication currently used by your child:

❑ Speech ❑ Gestures ❑ Taking person to desired item
❑ Pointing ❑ Facial Expressions ❑ Sign Language
❑ Vocalizations ❑ Augmentative Device (pictures, high tech system, etc.)

How often does your child use speech? ❑ Always ❑ Frequently ❑ Sometimes ❑ Rarely ❑ Never

How does your child primarily make his/her needs known? _____

How well is your child understood by familiar listeners (parents, siblings, friends)? _____

How well is your child understood by unfamiliar listeners? _____

How do you currently try to help your child with his/her communication skills? Are you currently using any pictures or signs within the home or school environment? _____

Does your child have trouble initiating and maintaining eye contact?	❑ No	❑ Yes
Is your child aware of his/her communication difficulties?	❑ No	❑ Yes
Does your child have difficulty attending or responding when spoken to?	❑ No	❑ Yes
Do you find yourself frequently repeating what you've said or directions you've given?	❑ No	❑ Yes
Do you have concerns with your child's short-term memory skills?	❑ No	❑ Yes
Does your child have difficulty responding to WH questions (who, what, where, etc.)?	❑ No	❑ Yes
Does your child have a hard time asking questions?	❑ No	❑ Yes
Do you have difficulty following a story that your child is telling?	❑ No	❑ Yes
Do they omit relevant details when telling a story?	❑ No	❑ Yes
Does your child exhibit signs of word retrieval difficulty (uses words wrong, labels things as 'this' or 'that' rather than using the word, frequently says 'uh' or 'um')?	❑ No	❑ Yes
Does your child have difficulty initiating play with other children?	❑ No	❑ Yes
Does your child struggle to take turns within play/conversation with others?	❑ No	❑ Yes
Does your child have trouble understanding or picking up on nonverbal language (e.g. body language, facial expression, tone of voice)?	❑ No	❑ Yes
Does your child have a decreased interest in playing/interacting with peers?	❑ No	❑ Yes
Do you have any concerns with your child's behaviors that may be related to his or her speech and language difficulties?	❑ No	❑ Yes
Does your child show signs of frustration during times of communication breakdown?	❑ No	❑ Yes

If you answered yes to any of the above questions, please describe: _____

What level of direction can your child follow? (check all that apply) ❑ One Step ❑ Multiple Steps ❑ Routine ❑ Unfamiliar

Please provide any further information that would help us understand your child and his/her present communication abilities:

_____

_____

ACTIVITIES OF DAILY LIVING

SLEEP SKILLS

Where does your child sleep? _____

Does your child take naps? ❑ No ❑ Yes

If yes, please answer: Frequency of naps: _____ Duration of naps: _____

Please describe any specific details regarding naptime and bedtime routines: _____

_____

_____

What activities are a part of your child's bedtime routine? (Check all that apply)

❑ Bath time	❑ Singing/humming	❑ Reading
❑ Bouncing	❑ Massage	❑ Rocking
❑ Holding	❑ Comfort items	❑ Other:

Does your child have difficulty:

❑ Falling asleep	❑ Staying asleep	❑ Night terrors
❑ Frequent night waking	❑ Other:	

How many times per night does he/she wake?

❑ Almost never	❑ 1-3	❑ 4-5

What does your child do when he/she awakens?

❑ Whimper	❑ Puts self back to sleep	❑ Scream
❑ Plays with toys	❑ Calls for parent	❑ Goes to parents' bedroom
❑ Other:		

What activities do you use to get your child back to sleep?

❑ Feeding	❑ Singing/humming	❑ Reading
❑ Holding	❑ Bouncing	❑ Rocking
❑ Massage	❑ Other:	

TOILETING

Does your child experience urinary/bowel issues or difficulty? ❑ No ❑ Yes

If yes, please specify and indicate frequency each occurs:

❑ Constipation: _____	❑ Loose stools: _____	❑ Bedwetting: _____
❑ Lack of awareness: _____	❑ Incontinence during the day	❑ Other: _____
	❑ Bowel: _____	
	❑ Bladder: _____	

Does your child have difficulty-wiping self after toileting? ❑ No ❑ Yes

What routines are helpful for getting your child to participate in toileting? _____

_____

_____

FEEDING SKILLS

Is there a disruption in family mealtime as a result of your child's eating patterns? ❑ No ❑ Yes

If yes, please comment: _____

_____

Does your child refuse to eat, spit out, or gag on foods? ❑ No ❑ Yes

If yes, based on which characteristics:

- ❑ Temperature
- ❑ Chewy foods
- ❑ Food color
- ❑ Smells
- ❑ Mixed food textures
- ❑ Other:
- ❑ Crunchy foods
- ❑ Food texture

Does your child exhibit any oral behaviors? ❑ No ❑ Yes

If yes, check all that apply:

- ❑ Examines objects by placing in mouth
- ❑ Pocket food/stuffs food, drool, very messy eater
- ❑ Bites/chews objects/clothing frequently
- ❑ Examines objects through smell
- ❑ Grinds teeth
- ❑ Gags/vomits frequently
- ❑ Very messy eater
- ❑ Excessive drooling

Does your child have difficulty sitting during meals? ❑ No ❑ Yes

My child can sit for:

- ❑ 1-2 minutes
- ❑ 3-5 minutes
- ❑ 6-10 minutes
- ❑ Entire meal

Does your child: (Check all that apply)

- ❑ Feed self with spoon
- ❑ Feed self with fork
- ❑ Cut food with a knife
- ❑ Drink with a cup
- ❑ Open snack and juice boxes
- ❑ Drink through a straw

Does your child have any medical issues related to feeding? ❑ No ❑ Yes

If yes, please comment: _____

_____

What routines are helpful for getting your child to participate in mealtime or feeding activities? _____

_____

_____

GROOMING

Does your child dislike or resist grooming activities? ❑ No ❑ Yes

If yes (check all that apply):

- ❑ Tooth brushing
- ❑ Blowing nose
- ❑ Hair washing
- ❑ Hair brushing/combing
- ❑ Face washing
- ❑ Nail trimming
- ❑ Bathing
- ❑ Haircuts
- ❑ Other(s): _____

Does your child avoid or fear grooming devices? ❑ No ❑ Yes

If yes (check all that apply):

- ❑ Electric toothbrushes
- ❑ Barber's clippers
- ❑ Dentistry tools
- ❑ Other(s):

Does your child avoid or fear the sounds associated with grooming activities: ❑ No ❑ Yes

- ❑ Bath water
- ❑ Hair dryer
- ❑ Hand dryer
- ❑ Toilet flushing
- ❑ Other(s): _____

DRESSING

Which clothing is your child able to ***Take Off*** independently?

❑ Underwear ❑ Pants ❑ Shirt
❑ Shoes ❑ Socks ❑ Coat

Which clothing is your child able to ***Put On*** independently?

❑ Underwear ❑ Pants ❑ Shirt
❑ Shoes ❑ Socks ❑ Coat

Which fasteners can your child manage independently?

❑ Snaps ❑ Zippers ❑ Buttons
❑ Tie shoes

Was it a struggle learning to tie shoes?	❑ No	❑ Yes
Does your child tend to put clothes on backwards or inside out?	❑ No	❑ Yes
Does your child have difficulty with trying on or wearing new clothes?	❑ No	❑ Yes
Does your child struggle with clothing changes for cold/warm seasons (e.g. switching from long to short sleeves?)	❑ No	❑ Yes
Does your child frequently adjust clothing, as if uncomfortable?	❑ No	❑ Yes
Do tags in clothing or seams in socks bother your child?	❑ No	❑ Yes
Is your child selective in the types of clothing he/she will wear (e.g. hats, mittens, jeans, button shirts, layered clothes)?	❑ No	❑ Yes

If you answered yes to any of the above questions, please describe the reaction or behavior seen: _____

_____

_____

What types of clothing or textures are preferred _____

_____

_____

What types of clothing or textures are avoided? _____

_____

_____

What routines and/or assistance are helpful for getting your child to participate in dressing activities (please indicate how much assistance and prompting are needed for success)? _____

_____

_____

SOCIAL PARTICIPATION/FAMILY LIVING/BEHAVIORAL RESPONSES

Are you limited in attending family/social gatherings because of your child's behavior or reactivity to events? ❑ No ❑ Yes

Does your child struggle with transitions? ❑ No ❑ Yes

Does your child have comfort items that help him/her transition or engage in social situations? ❑ No ❑ Yes

Does your child have difficulty tolerating social touch or hugs from others? ❑ No ❑ Yes

If you answered yes to any of the above questions, please describe the reaction or behavior seen: _____

_____

_____

_____

Does your child have a hard time dealing with people's voices? ❑ No ❑ Yes

If yes, check all that apply:

❑ Loud or raised voices ❑ Singing ❑ Men's voices
❑ Women's voices ❑ Children's voices ❑ Screaming
❑ Cheering ❑ Crying

Does your child exhibit aggressive behavior? ❑ No ❑ Yes

If yes: Is it directed toward him/herself? ❑ No ❑ Yes

If yes: Is it directed toward others? ❑ No ❑ Yes

What types of behaviors are exhibited? (Check all that apply)

❑ Biting ❑ Kicking ❑ Pinching
❑ Hitting ❑ Spitting ❑ Other:

Does your child exhibit meltdowns and/or tantrums? ❑ No ❑ Yes

If yes: How frequently do they occur? _____ times/day OR _____ times/week

On average, how long does a meltdown/tantrum last? _____

Are tantrums a source of distress to other family members? ❑ No ❑ Yes

What triggers the meltdowns/tantrums? _____

_____

_____

Describe the strategies that are effective for helping calm your child during and after a meltdown/tantrum _____

_____

_____

_____

Does your child exhibit repetitive behaviors? ❑ No ❑ Yes

If yes: which behaviors are demonstrated? (Check all that apply)

❑ Hand Flapping	❑ Breath holding	❑ Self-talk
❑ Head banging	❑ Teeth grinding	❑ Rocking
❑ Spinning self	❑ Spinning objects	❑ Biting
❑ Humming	❑ Visual fixing	❑ Jumping
❑ Mouthing objects	❑ Smelling	❑ Other(s) (please describe):

What routines are helpful for getting your child to participate in social situations? _____

_____

_____

PLAY SKILLS/PEER INTERACTION

How long can your child play alone?

❑ Less than 2 mins	❑ 2-5 mins	❑ 5-10 mins
❑ 10-30 mins	❑ more than 30 mins	

Does your child have difficulty conceiving play ideas and/or organizing a plan to direct play? ❑ No ❑ Yes

Does your child have difficulty with imaginative play? ❑ No ❑ Yes

Which playground equipment will your child ***play on***? (Check all that apply)

❑ Swings	❑ Monkey bars	❑ Slide
❑ Ladders	❑ Climbing wall	❑ Bridges
❑ Vertical climbers	❑ Merry-go-round	❑ Spring riders
❑ Crawl tunnels	❑ Teeter Totter	❑ Other(s):

Which playground equipment will your child ***avoid***? (Check all that apply)

❑ Swings	❑ Monkey bars	❑ Slide
❑ Ladders	❑ Climbing wall	❑ Bridges
❑ Vertical climbers	❑ Merry-go-round	❑ Spring riders
❑ Crawl tunnels	❑ Teeter Totter	❑ Other(s):

Please indicate the following skills your child can do:

❑ Kick a ball	❑ Pump a swing	❑ Ride a bike with training wheels
❑ Throw a ball with accuracy	❑ Ride a scooter	❑ Ride a bike without training wheels
❑ Catch a ball	❑ Ride a tricycle	❑ Alternate feet going up and coming down stairs

Was it a struggle for your child to learn any of the skills listed above? ❑ No ❑ Yes

If yes can you please comment on what was challenging and any strategies that you have found assist your child to learn new motor skills: _____

_____

_____

Please check any of the following items that pertain to or describe your child:

- ❑ Difficulty making friends
- ❑ Seems to lack self confidence
- ❑ Tends to be bossy or pushy
- ❑ Has trouble getting along with other children
- ❑ Gets easily frustrated
- ❑ Can have strong outbursts of anger
- ❑ Is more often active and intense
- ❑ Tends to be impulsive
- ❑ Poor safety awareness
- ❑ Tends to be cautious
- ❑ Becomes anxious easily
- ❑ Is more often quiet and withdrawn
- ❑ Has difficulty separating from parents
- ❑ Tends to be very set in his/her routines
- ❑ Prefers to play with older children/adults
- ❑ Prefers to play with younger children
- ❑ Prefers to play alone
- ❑ Prefers to sit back and let others lead
- ❑ Prefers active play
- ❑ Prefers sedentary play
- ❑ Does better one on one
- ❑ Has difficulty with large groups
- ❑ Immature for age
- ❑ Needs more protection than other children
- ❑ Touches people incessantly
- ❑ Has difficulty understanding personal space
- ❑ Lacks a sense of humor
- ❑ Sensitive to criticism

MOVEMENT SKILLS

Does your child appear calmer after movement activities?	❑ No	❑ Yes
Does your child like to be wrapped tightly in a sheet or blanket, or seek tight spaces?	❑ No	❑ Yes
Does your child shake his/her head vigorously?	❑ No	❑ Yes
Does your child assume an upside down position frequently?	❑ No	❑ Yes
Does your child become overly excited after movement activities?	❑ No	❑ Yes

If you answered yes to any of the above questions, please describe: _____

_____

_____

Is your child preoccupied with seeking intense movement during play? ❑ No ❑ Yes

If yes, check all that apply

- ❑ Spinning
- ❑ Bouncing
- ❑ Crashing
- ❑ Rocking
- ❑ Jumping
- ❑ Other(s): _____

Does your child display any of the following movement difficulties? (Check all that apply) ❑ No ❑ Yes

- ❑ Avoids age-appropriate gross motor activities
- ❑ Poor sense of direction or awareness of space
- ❑ Seems weaker or tires more easily than peers
- ❑ Fearful of being tossed in the air or turned upside down
- ❑ Excessive dizziness from swinging or spinning
- ❑ Experiences motion sickness in cars, trains, boats, etc.
- ❑ Drags hand on wall or bangs objects when walking
- ❑ Walks into things or trips over objects on the floor
- ❑ Poor coordination or sense of rhythm
- ❑ Walks on his/her toes
- ❑ Fears falling when no real danger exists
- ❑ Fearful of heights and/or stairs
- ❑ Avoids activities where feet leave the ground
- ❑ Stamps/slaps feet on ground when walking
- ❑ Loses balance/trips easily or frequently
- ❑ Avoids/fears activities requiring balance

SCHOOL PERFORMANCE/HOMEWORK

Hand preference: ❑ Right ❑ Left ❑ Not established

What can your child write accurately?

❑ Name ❑ Numbers ❑ Address

❑ Sentence ❑ Paragraph

Does your child have difficulty holding tools (pencils, scissors) appropriately?	❑ No	❑ Yes
Does your child have a hard time cutting with scissors?	❑ No	❑ Yes
Does your child slump or move in and out of his/her chair while doing work?	❑ No	❑ Yes
Does your child get overwhelmed when there is a lot of information on a page?	❑ No	❑ Yes
Does your child demonstrate inefficient ways of doing things (e.g. getting started, organizing work, wasting time, finishing projects on time)?	❑ No	❑ Yes

If yes, please describe: _____

_____

_____

Please check off any areas that you feel your child is struggling with in school:

❑ Sitting still	❑ Finishing work	❑ Spelling
❑ Paying attention	❑ Social interactions	❑ Reading
❑ Following directions	❑ Following the rules	❑ Mathematics
❑ Organizing work	❑ Group activities	❑ Written tasks
❑ Working independently	❑ Specials (Gym, Music, etc.)	❑ Other:

Please describe the strategies that help your child complete homework _____

_____

_____

_____

What extracurricular activities does your child participate in? _____

_____

_____

Thank you for sharing this information with us!
If you have any additional comments or questions, please feel free to discuss them with your therapist!

Compiled by S. Szklut MS, OTR/L, S. Man MS, OTR/L, and S. Welch MS, OTR/L with significant contributions from Therapeutic Listening's Functional Listening Questionnaire, The Listening Program Client History- Child Form, and OTA-Watertown's Developmental History