South Shore
THERAPIES

DEVELOPMENTAL HISTORY *Ages 0-3 years*

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

_____
nickname

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

Child's Pre-School/Daycare: _____

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 0-3 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/Colic
- ❑ 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 Device
- ❑ 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. (e.g. 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 your child part of a multiple pregnancy? ❑ No ❑ Yes: ❑ Twins ❑ Triplets ❑ Other: _____

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

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

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

_____

_____

_____

Child's Birth Weight: _____ Apgar Scores: _____

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

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

❑ Inconsolable crying	❑ Strong startle w/ noises	❑ Cried when lifted up
❑ Not calmed by cuddling	❑ Cried w/ head tipped back	
❑ Startled when approached	❑ Resistance to tummy time	

Please comment on any past stressful events:

_____

_____

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 the age at which your child met the following developmental milestones (if applicable):

Spoke first word: _____ Combined words: _____ Spoke sentences: _____

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

❑ Speech ❑ Gestures ❑ Pointing
❑ Taking person to desired item ❑ Facial expression ❑ Sign language
❑ Vocalizations ❑ Augmentative Device (pictures, high tech system, etc.) ❑ Other:_____

How often does your child use speech?

❑ Frequently ❑ Sometimes ❑ Rarely ❑ Never

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? _____

_____

What level of direction can your child follow? (check all that apply)

❑ One step ❑ Multiple steps ❑ Routine ❑ Unfamiliar

Does your child have trouble initiating or maintaining eye contact?	❑ 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, when, etc.)	❑ No	❑ Yes
Does your child have a hard time asking questions?	❑ No	❑ Yes
Do you have a hard time following a story that your child is telling?	❑ No	❑ Yes
Does your child omit relevant details when telling a story?	❑ No	❑ Yes
Does your child have difficulty initiating play with other children?	❑ No	❑ Yes
Does your child have difficulty taking turns within play or conversations 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 decreased interest in playing or interacting with peers?	❑ No	❑ Yes
Do you have any concerns with your child's behavior that might be related to his or her speech and language difficulties?	❑ No	❑ Yes
Is your child aware of his or her communication 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 comment: _____

_____

_____

_____

ACTIVITIES OF DAILY LIVING

The following sections provide us with important information about developmental milestones and behaviors that are useful in helping us understand more about your child. Please note, there is a wide variability in skill between ages 0-3 so not all milestones listed are expected to be relevant to your child. Please fill these sections out to the best of your ability, checking all that apply and indicating age (if known), frequency, and other relevant details where specified.

SLEEP

Does your child sleep through the night? ❑ No ❑ Yes (Age when first occurred: _____)

Is your child able to fall asleep on his/her own? ❑ No ❑ Yes (Age when first occurred: _____)

On average, how many hours a night does your child sleep? _____

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 part of your child's bedtime routine? (Check all that apply)

❑ Bath time ❑ Singing/Humming ❑ Reading
❑ Bouncing ❑ Massage ❑ Rocking
❑ Holding/Hugging ❑ Comfort items ❑ Other: _____
❑ Bottle Feeding/Nursing ❑ Pacifier/Thumb sucking _____

Does your child have difficulty with any of the following?

❑ Falling asleep ❑ Staying asleep ❑ Night terrors
❑ Frequent 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 ❑ Calls for parents ❑ Goes to parents' room
❑ Cries ❑ Plays with toys ❑ Other: _____
❑ Screams ❑ Puts self back to sleep _____

What activities do you do to put your child back to sleep?

❑ Holding ❑ Singing/Humming ❑ Bouncing
❑ Massage ❑ Rocking ❑ Other: _____

EATING/ MEALTIME

Has your child experienced any of the following?

- ❑ Difficulty with breast feeding
- ❑ Difficulty with bottle feeding
- ❑ Difficulty with baby food
- ❑ Difficulty eating soft solids
- ❑ Difficulty eating mixed textures
- ❑ Difficulty with transition from bottle to cup
- ❑ Reflux (# Months) _____
- ❑ Colic (# Months) _____

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 Textures
- ❑ Other: _____
- ❑ Crunchy Foods
- ❑ Food Texture

Does your child exhibit oral behaviors? ❑ No ❑ Yes

If yes, check all that apply:

- ❑ Excessive mouthing of objects
- ❑ Bites/chews objects/clothing frequently
- ❑ Examines objects through smell
- ❑ Gags/vomits frequently
- ❑ Excessive drooling
- ❑ Grinds teeth
- ❑ Very messy eater
- ❑ Mouth stuffing
- ❑ Pockets food

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

Where does your child sit for meals (location and type of seat)?

_____

My child can sit for:

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

Does your child: (Check all that apply)

- ❑ Drink from a bottle with help
- ❑ Drink from a bottle without help
- ❑ Drink from cup with help
- ❑ Drink from a cup without help
- ❑ Finger feed self
- ❑ Feed self with spoon
- ❑ Feed self with fork
- ❑ Open containers
- ❑ Use a straw

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

If yes, please comment: _____

_____

_____

_____

DRESSING

Please indicate whether or not your child has met the following milestones:

- ❑ Cooperates in dressing by moving limbs
- ❑ Pulls off shoes, socks, hats or mittens
- ❑ Undoes large buttons, snaps, shoelaces
- ❑ Undresses completely (except fasteners)
- ❑ Tries to put on shoes
- ❑ Puts on simple clothes without assistance
- ❑ Puts on coat, dress, t-shirt (except buttoning)
- ❑ Zips/unzips zipper

Does your child attempt to help with fasteners? (Velcro, seat buckles, etc.) ❑ 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 and seams in clothes 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, etc.) ❑ No ❑ Yes

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

_____

_____

What types of clothing are preferred? _____

_____

What types of clothing are avoided? _____

_____

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

_____

_____

GROOMING/HYGIENE

Please indicate whether or not your child has met the following milestones:

- ❑ Attempts to brush hair
- ❑ Attempts to wash face or hands
- ❑ Cooperates with tooth-brushing
- ❑ Spits out toothpaste
- ❑ Washes and dries hands with assistance
- ❑ Washes and dries hands independently
- ❑ Maintains safe body position while bathing

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

If yes, check all that apply:

- ❑ Toothbrushing
- ❑ Blowing nose
- ❑ Hair washing
- ❑ Hair brushing/combing
- ❑ Face washing
- ❑ Nail trimming
- ❑ Bathing
- ❑ Hair cuts
- ❑ Other:

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

If yes, check all that apply:

- ❑ Electric toothbrushes
- ❑ Barber's clippers
- ❑ Dentist tools
- ❑ Other: _____

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

If yes, check all that apply:

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

TOILETING

Does your child wear diapers? ❑ No ❑Yes

If yes, check all that apply:

❑ Remains dry 1-2 hour periods
❑ Indicates when wet/soiled
❑ Appears to be aware when urinating
❑ Appears to be aware when moving bowels
❑ Appears to have awareness of need to go beforehand

Have you initiated toilet training? ❑ No ❑Yes

If yes, check all that apply:

❑ Uses gestures or words to indicate need to use toilet
❑ Uses toilet for urine (Age when started: _____)
❑ Uses toilet for bowel movements (Age when started:_____)
❑ Toilets independently (except wiping)
❑ Often holds urine/bowel until at home

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

If yes, please specify and indicate frequency each occurs:

❑ Constipation: _____ ❑ Loose stools: _____ ❑ UTI: _____

❑ Lack of awareness: _____ ❑ Other: _____

❑ Accidents during the day (if toilet trained):
- ❑ Bladder:
- ❑ Bowel:

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

_____

_____

_____

Please share any additional information regarding challenges in your daily routines: _____

_____

_____

_____

Please share any strategies you have found that help your child with daily routines (e.g. specific routines, verbal directions/warnings, visual modelling, picture schedules, reward chart, etc.) _____

_____

_____

_____

SOCIAL PARTICIPATION/FAMILY LIVING/BEHAVIORAL RESPONSES

Does your child have any difficulties with social engagement? ❑ No ❑ Yes
Are you limited in attending 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
If yes, what is/are your child's comfort object(s)?

Does your child have difficulty tolerating social hugs or touch from others? ❑ No ❑ Yes
If you answered yes to any of the above questions, please describe the reaction or behavior you have seen:

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

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

If yes, check all that apply:

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

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 these a source of distress for other family members? ❑ No ❑ Yes

What triggers a meltdown/tantrum? _____

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

Does your child exhibit repetitive behaviors? ❑ No ❑ Yes

If yes, which of the following 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/staring ❑ Jumping
❑ Smelling ❑ Other: _____

PLAY SKILLS/SOCIAL INTERACTIONS

How long can your child play alone?

❑ Less than 2 minutes ❑ 2-5 minutes ❑ 5-10 minutes
❑ 10-30 minutes ❑ More than 30 minutes

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

What playground equipment will your child ***play on?*** (check all that apply)

❑ Swings ❑ Ladders ❑ Teeter totter
❑ Slides ❑ Bridges ❑ Merry-go-round
❑ Spring riders ❑ Crawl tunnels ❑ Vertical climbers
❑ Other: _____

What playground equipment will your child ***avoid?*** (check all that apply)

❑ Swings ❑ Ladders ❑ Teeter totter
❑ Slides ❑ Bridges ❑ Merry-go-round
❑ Spring riders ❑ Crawl tunnels ❑ Vertical climbers
❑ Other: _____

Please indicate which of the following play skills your child has accomplished:

❑ Bangs toys together
❑ Understands cause and effect
❑ Plays "give and take" games cooperatively (e.g. passing a ball)
❑ Imitates actions (Peek-a-Boo, clapping, "So Big")
❑ Makes connections with items (e.g. takes DVD over to TV)
❑ Explores a variety of ways to play with new toy/object
❑ Plays pretend (e.g. feeds a doll, talks in phone)
❑ Propels a riding toy with feet/rides a tricycle
❑ Throws a ball
❑ Kicks a ball

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 to 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
❑ Has 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 alone
❑ Prefers to sit back and let others lead
❑ Prefers active play
❑ Prefers sedentary play
❑ Does better one on one
❑ Needs more protection than other children
❑ Touches people incessantly
❑ Has difficulty understanding personal space
❑ Lacks a sense of humor
❑ Has difficulty with imaginary play

GROSS MOTOR

Please indicate which developmental milestones your child has achieved and the age at which it first occurred (where indicated):

- ❑ Pushes through arms when laying on belly
- ❑ Rolls over (age: _____)
- ❑ Sits unsupported (age: _____)
- ❑ Crawls (age: _____)
- ❑ Pulls to stand using furniture
- ❑ Stands alone
- ❑ Walks (age: _____)
- ❑ Creeps up stairs
- ❑ Walks up stairs (two feet on each step)
- ❑ Walks up stairs (alternating feet)
- ❑ Walks down stairs (two feet on each step)
- ❑ Walks down stairs (alternating feet)
- ❑ Climbs in/out of chair
- ❑ Climbs in/out of bed
- ❑ Climbs in/out of car
- ❑ Can stand on one foot
- ❑ Jumps with two feet
- ❑ Runs

How does your child respond to movement (e.g. being tossed in the air, swings, rocking, car rides, etc.)? _____

_____

_____

Does your child like to be wrapped tightly in a sheet or blanket, or seek tight spaces? ❑ No ❑ Yes

Does your child frequently seek intense movement during play? ❑ No ❑ Yes

If yes, check all that apply:

- ❑ Spinning
- ❑ Rocking
- ❑ Bouncing
- ❑ Jumping
- ❑ Crashing
- ❑ Other: _____
- ❑ Going upside-down
- ❑ Shaking his/her head

Does your child display any of the following movement difficulties?

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

FINE MOTOR

Has your child developed a hand preference? ❑ No ❑ Yes

If yes, which hand? ❑ Right ❑ Left

Please indicate which developmental milestones your child has achieved (as applicable):

- ❑ Reaches for objects in front of him/her
- ❑ Transfers objects from one hand to the other
- ❑ Brings toys and objects to mouth
- ❑ Rakes or scoops up small food pieces
- ❑ Turns pages of cardboard books
- ❑ Puts objects into containers
- ❑ Dumps objects out of containers
- ❑ Stacks, takes apart, and puts together toys
- ❑ Removes screw top lid
- ❑ Builds using blocks
- ❑ Picks up small objects using thumb and index finger
- ❑ Holds crayon with fingers and thumb
- ❑ Scribbles with circular motion
- ❑ Imitates drawing horizontal and vertical lines
- ❑ Copies simple shapes
- ❑ Snips with scissors
- ❑ Strings large beads
- ❑ Turns a doorknob
- ❑ Can manipulate small toy parts (buttons, levers, etc.)
- ❑ Pours from one container to another

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, Alexa Howell 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, Developmental Programming for Infants and Young Children, Early Intervention Developmental Profile, and OTA-Watertown's Developmental History