DEVELOPMENTAL AND MEDICAL HISTORY

Today's Date _______________

Child's Name ______________________________________Date Of Birth_______________ Sex: M F

Parent/Guardian Name(s)____
If child does not live with both parents, who has legal custody of the child?_____________________
Name of Person Completing This Form _____________________Relationship ____________________

Sibling Names	Date of Birth	Sex	Living at Home with Child?

PATIENT INFORMATION

Diagnosis:____
____
Allergies/Precautions:____
____
Dietary Restrictions:____
____
Attempted Solutions for Concerns:____
____

HELP US TO GET TO KNOW YOUR CHILD AND FAMILY

Child's favorite activities: ____
Your child's likes (food, toys, shows, movies): ____
____
Your child's dislikes (things that upset them or things to avoid): ____________________________
____
What upsets your child ? (may cause tantrums, outbursts, anxiety) ___________________________
____
Is your child involved in any extracurricular activities? Please list them.
____
How does your child typically spend their time? ____
____

Describe the environment in which they spend the majority of their. ______________________________
____
____

What responsibilities/roles/chores does your child have around the home?
____
____

What personality trait best describes your child? ____
____

What do you view as your child's strengths? ____
____
____

What areas do you see as challenging for your child? ____
____
____

Describe some of your family's favorite places, activities, or community outings.
____
____
____

Please list any other pertinent information you would like to share about your family or your child.____
____
____
____

What are your primary concerns regarding your child? ____
____
____
____

PRENATAL HISTORY

Did you experience any complications, illnesses, or stressors during this pregnancy?____ NO ____ YES
If yes, please explain: ____
____
____

BIRTH HISTORY

Please mark: _____Full Term ______Premature ______Postmature
_____C-Section ______Vaginal ______Breech
_____Forceps Used ______Suction Required

Number of Weeks: __________ Birth Weight: ______________

Was there a need for:

Oxygen______ NO ______ YES Transfusions______ NO ______ YES Tube feedings______ NO ______ YES

Breast-fed_______ NO _______ YES How long? __________________________

Bottle-fed _______ NO _______ YES How long? __________________________

Strong Suck _______ NO _______ YES

Spit up frequently? _______ NO _______ YES

Please mark: _______Irritable baby _______Happy baby _______Quiet baby

Problems with feeding/ respiration/ sleeping. *(Circle).* Please explain. ____________________________
____
____

DEVELOPMENTAL HISTORY

Developmental Milestone	Month Achieved	Comments
Held head up		
Rolled over		
Sat unsupported		
Crawled		
Cruised		
Walked		
Said first words		
Spoke in sentences		
Put a few words together		
Toilet trained (bladder)		
Toilet trained (bowels)		
Undressed self		
Dressed self		
Managed buttons, zippers etc.		
Ate solid foods		
Drank from an open cup		
Used a straw		

Please describe any concerns you noted in your child's development.
____
____
____
____
____

INFANCY AND EARLY CHILDHOOD

Please check the behaviors that describe your child.

Behavior	Often	Sometimes	Seldom/Never	Comments
Fussy				
Easy to calm				
Lethargic				
Passive				

Active				
Colicky				
Difficult to calm				
Cried easily				
Trouble sleeping				
Liked being held				
Disliked being held				
Tense when held				
Like being on stomach				
Enjoyed bouncing				
Enjoyed car rides				

HEALTH CONDITIONS

Please check if child has had the following:

Condition	Yes	No	Condition	Yes	No
Abnormal spinal curvature			Emotional problems		
Allergies			Frequent headaches		
Arthritis			Heart problems		
Bed-wetting at night			High fevers		
Behavior problems			Measles		
Birth or congenital malformation			Meningitis		
Cancer			Multiple Ear infections (3 or more)		
Chicken Pox			Nervous tics		
Chronic diarrhea			Re-flux or GERD		
Chronic constipation			Seizures		
Cystic Fibrosis			Sleeping problems		
Diabetes			Tonsils/Adenoid Problems		
Eczema			Upper Respiratory Infections		
Frequent cold/sinus issues			Urinary tract infections		
Feeding difficulties			Wetting during the day		
Frequent spitting up			Vision problems		
Fluid in ears			Other:		

Hospitalizations? _______ NO _______ YES

If Yes, please explain: ____

Evaluation	Yes	No	Date and Results
Vision			
Hearing			

Please list any medication your child is currently taking:

Medication	Dosage/Frequency	Purpose of medication

Are there any medical precautions, behaviors or other precautions the therapist should be aware of?____

____

EDUCATION HISTORY

Name of School: ____

Current Grade: ____

Classroom type: ____

If attending school part-time:

Days attended ____________________ Time of day __________________________

Does your child receive any special services at school? ______ NO ______ YES

If yes, please list the amount of services in each area:

OT ______________ Speech _____________

PT ______________ Resource ____________

What is the primary goal or skill you would like to see your child achieve?

____

____

____

What hopes and dreams do you have for your child and family?

____

____