

## Developmental, Medical, and Sensory History

**Parents:** This history appears to be quite long. However, many of the questions require only “check off” responses that can be completed quickly. The information you are providing is extremely useful in gaining a clear understanding of your child’s abilities. We truly appreciate the time you are taking to complete it!

### General Information:

Child’s Name: \_\_\_\_\_  
(first) (last) (nickname)

Date of Birth: \_\_\_\_\_

Mother’s Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father’s Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name and ages of brothers and sisters: \_\_\_\_\_

### Birth History:

Was there anything unusual about the pregnancy or birth?      Yes      No  
If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

How old was the mother when the child was born? \_\_\_\_\_

Was the child born early?      Yes      No  
If yes, how many weeks was the mother at the time of the delivery? \_\_\_\_\_

Did the child go home with his/her mother from the hospital?      Yes      No  
If the child stayed at the hospital, please describe why and how long. \_\_\_\_\_

\_\_\_\_\_

### Medical History:

Has your child had any of the following?

- |                        |               |                            |
|------------------------|---------------|----------------------------|
| adenoidectomy          | encephalitis  | seizures                   |
| allergies:             | flu           | sinusitis                  |
| breathing difficulties | head injury   | sleeping difficulties      |
| chicken pox            | high fevers   | thumb/finger sucking habit |
| colds                  | measles       | tonsillectomy              |
| ear infections         | meningitis    | tonsillitis                |
| How often? _____       | mumps         | vision problems            |
| ear tubes              | scarlet fever |                            |

Describe any allergies your child may have: \_\_\_\_\_

\_\_\_\_\_

Other serious injury, surgery, or hospitalization (please list incident and dates): \_\_\_\_\_

\_\_\_\_\_

List any medications your child is currently receiving, along with frequency and dosages: \_\_\_\_\_

\_\_\_\_\_

Purpose and effect of medication: \_\_\_\_\_

\_\_\_\_\_

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision therapy, etc.)?

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

**Are there any medical precautions we should be aware of when working with your child?** \_\_\_\_\_

\_\_\_\_\_

**Developmental Milestones:** Please give approximate ages if remembered and comment on anything unusual, such as method used for "crawling."

Rolling over: from stomach: \_\_\_\_\_ from back: \_\_\_\_\_ Sitting alone: \_\_\_\_\_

Crawling: \_\_\_\_\_ Was crawling phase brief, absent, or unusual? \_\_\_\_\_

Walk as a primary form of getting around: \_\_\_\_\_

Babble: \_\_\_\_\_ Say words: \_\_\_\_\_ Say sentences: \_\_\_\_\_

Did your child experience any hesitancy or delays in learning to go down stairs? Yes No

Please describe how your child communicates: \_\_\_\_\_

\_\_\_\_\_

**Sensory History:** Please check the appropriate area. *Comment as desired and cross out any parts of questions that do not fit your child.*

<b>Visual-Spatial Processing</b> Does your child:	<b>Often</b>	<b>Some- times</b>	<b>Rarely/ Never</b>	<b>Comments</b>
Look away from tasks to notice all actions in the room?				
Become easily distracted by visual stimulation?				
Dislike having eyes covered?				
Like playing in the dark?				
Become frustrated when trying to find objects in “busy” backgrounds (e.g., an overfilled drawer)?				
Tend to draw some numbers and letters backwards?				
Blink or squint at lights (e.g., sunlight through car window)?				
Have difficulty discriminating shapes or colors?				
Squint or use one eye when looking at toys?				
Explore using peripheral vision?				
Watch everyone when they move around the room?				
Not notice when people come into the room?				
Look carefully or intensely at objects or people?				
Avoid or have difficulty with eye contact?				
Have difficulty putting puzzles together?				
Seem fearful of catching balls?				

<b>Communication and Auditory Processing</b> Does your child:	<b>Often</b>	<b>Some- times</b>	<b>Rarely/ Never</b>	<b>Comments</b>
Like to sing or dance to music?				
Have difficulty maintaining or copying rhythms?				
At times, seem not to understand what is said?				
Does he/she point to objects?				
Seem unnecessarily sensitive to sounds?				
Become distracted by background noises such as refrigerators, fluorescent lights, fans, etc.?				
Seem to have trouble remembering what is said?				
Have speech or articulation difficulties?				
Have difficulty initiating an interaction?				
Have trouble expressing what he or she wants?				
Have difficulty following two or three directions given at once?				
Like to decrease the volume on the television?				
Like to increase the volume on the television?				
Use a voice that is too loud or too soft?				
Seem to understand more than can be expressed?				
Enjoy strange noises or tend to make noise “for noise sake”?				
Seem confused about the direction of sound?				
Does he/she hear things before you hear them?				
Appear not to hear what you say?				
Talk self through tasks?				
Respond negatively to unexpected or loud noises (e.g., vacuum cleaner, dog barking, hair dryer)?				
Have difficulty following directions about his or her body?				

<b>Movement</b> Does your child:	<b>Often</b>	<b>Some- times</b>	<b>Rarely/ Never</b>	<b>Comments</b>
Enjoy swings?				
Enjoy merry-go-rounds or fast carnival rides?				
Like being tipped upside down or lifted overhead?				
Hesitate or avoid climbing on equipment such as jungle gyms?				
Dislike elevators or escalators?				
Walk on toes?				
Jump often on beds or other surfaces?				
Bang head on purpose?				
Rock in bed or unconsciously during activities?				
Tend not to alternate feet going down stairs?				
Hesitate going down steps or curbs?				
Like to spin self around?				
Become carsick easily?				
Get lost easily?				
Jump from one activity to another so frequently that it interferes with play?				
Becomes upset if head is tilted backwards as in hair washing?				

<b>Taste and Smell</b> Does your child:	<b>Often</b>	<b>Some- times</b>	<b>Rarely/ Never</b>	<b>Comments</b>
Tend to explore with smell or deliberately smell objects?				
Seem very sensitive to some smells?				
Dislike the taste and texture of many foods?				
Act as though all food taste the same?				
Have more difficulty eating textured than smooth foods?				
Prefer crunchy foods?				
Have difficulty or avoid eating smooth foods with a few lumps, Such as soup or chunky peanut butter?				
Lick, suck or chew on non-food items (past 18 months)?				
Enjoy spicy or very tart foods?				
What are your child's favorite foods?				

<b>Touch</b> Does your child:	<b>Often</b>	<b>Some- times</b>	<b>Rarely/ Never</b>	<b>Comments</b>
Seem excessively ticklish?				
Become irritated by tags in the back of shirts?				
Prefer to touch rather than to be touched?				
Dislike having nails clipped?				
Tend to examine objects by touching thoroughly with hands (past 2 years of age)				
Dislike or use too much force when petting animals?				
Complain if socks are not on correctly?				
Seem to crave being held and cuddled?				
Dislike being touched unexpectedly?				
Tend to prefer long sleeves and pants regardless of the weather?				
Tend to prefer no clothing regardless of the weather?				
Dislike cloth of certain textures?				
Avoid getting hands into paste, finger paints, or other messy materials?				

	Often	Sometimes	Rarely/ Never	Comments
Often seem excessively active?				
Tend to bump or push others?				
Tend to be more sensitive to pain than others?				
Become especially bothered by small cuts?				
Tend not to feel pain as much as others?				
Seem oblivious to bruises and heavy falls?				
Tend to remove shoes whenever possible?				
Complain that others often hit or push him or her?				
Become extremely irritated when splashed with water?				
Mouth objects or clothing frequently?				
Not noticed when face or hands are messy?				
Gag easily with food textures or utensils in mouth?				
Seem to have under active gag reflex?				
Leave clothing twisted on body?				
Seem overly sensitive to food or water temperature?				
Dislike having hair and face washed?				
Dislike having teeth brushed?				
React negatively to the feel of new clothing?				

<b>Social</b>	Often	Sometimes	Rarely/ Never	Comments
<b>Does your child:</b>				
Make friends easily?				
Tend to prefer to play alone?				
Have a strong desire for sameness and routine?				
Tend to crave attention?				
Seem sensitive to criticism?				
Lack self-confidence?				
Have trouble demonstrating emotions?				
Have strong outburst of anger or tantrums?				
Have trouble getting along with other children?				
Tend to be aggressive?				
Tend to be quiet and withdrawn?				
Tend to be impulsive or careless?				
Tend to be intense or easily frustrated?				
Tend to be in perpetual motion?				
Tend to be very set in his or her routines?				
Prefer the company of adults to children?				
Take a long time to warm up to new people and situations?				
Seem too serious?				
Have fears that interfere with daily routines?				

	Often	Sometimes	Rarely/ Never	Comments
Fluctuate from happy to sad or mad quickly with little apparent cause?				
Tend to be excessively affectionate with others?				
Seem discouraged or depressed?				

<b>Play</b> <b>Does your child:</b>	Often	Sometimes	Rarely/ Never	Comments
Play with toys purposefully?				
Imitate faces and gestures?				
Use objects in pretend play (e.g., blocks or caring for doll)?				
Play for more than 5 minutes at a time?				
Play alongside another child, modeling their behavior?				
Play cooperatively with other children?				
Prefer quiet, sedentary play?				
Prefer to play alone?				
Prefer to play with children who are 1 to 2 years younger?				
Initiate play with other children?				
Use pretend/symbolic play?				
Use rules during play?				

<b>Motor skills</b> <b>Does your child:</b>	Often	Sometimes	Rarely/ Never	Comments
Bump into things frequently?				
Have difficulty with several step tasks?				
Seem shaky when doing fine motor tasks?				
Seem weaker than others his or her age?				
Frequently grasp objects very tightly?				
Tend to break many objects?				
Tend to drop things easily?				
Tire easily with physical activity?				
Seem to deliberately fall or tumble?				
Tend to eat in a sloppy manner?				
Find small manipulative activities difficult?				
Prefer playground to table activities?				
Prefer table activities to playground activities?				
Tend to perform movements in a slow and prodding fashion?				
Appear reluctant to participate in sports and games?				
Tend to move in and out of the chair while eating or doing work?				
Feel heavier than expected when being lifted?				
Slump while sitting?				

	Often	Sometimes	Rarely/ Never	Comments
Have difficulty handling eating utensils?				
Frequently spill liquids?				
Drool?				
Keep his or her mouth open most of the time?				
Move stiffly or awkwardly?				
Have trouble chewing?				
Tend to be slow in dressing?				

**Bowel and Bladder**

**Does or did your child:**

Have trouble learning urinary control? \_\_\_\_\_ Continued to have accidents until age: \_\_\_\_\_

Have trouble learning bowel control? \_\_\_\_\_ Continued to have accidents until age: \_\_\_\_\_

Seem to have difficulty registering the need to eliminate? \_\_\_\_\_

Tend to masturbate or to "hold onto" him or herself frequently? \_\_\_\_\_

**Sleep Patterns**

**Does your child:**

Have regular sleep patterns? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

Wake frequently during the night? \_\_\_\_\_

Tend to need very little sleep? \_\_\_\_\_

Tend to have a difficult time falling asleep? \_\_\_\_\_

**Teacher and School Skills**

If enrolled in school, is your child considered to have difficulty in any of the following?

Check those that apply:

\_\_\_\_\_ Reading \_\_\_\_\_ Math \_\_\_\_\_ Spelling \_\_\_\_\_ Handwriting \_\_\_\_\_ Following Directions

\_\_\_\_\_ Finishing Tasks \_\_\_\_\_ Paying Attention \_\_\_\_\_ Organizing Work \_\_\_\_\_ Behavior

\_\_\_\_\_ Other: \_\_\_\_\_

Does your child receive special help? \_\_\_\_\_ Type? \_\_\_\_\_ How often? \_\_\_\_\_

Name of teacher: \_\_\_\_\_

Additional Comments regarding special services or educational plan:

\_\_\_\_\_  
\_\_\_\_\_

**Behavioral Characteristics:** (please check all that apply)

cooperative

attentive

willing to try new activities

plays alone for reasonable length of time

separation difficulties

easily frustrated/impulsive

stubborn

restless

poor eye contact

easily distracted/short attention

destructive/aggressive

inappropriate behavior

withdrawn

self-abusive behavior

### Developmental Skills:

Can your child:	Yes	No	Fair	Average	Good
Turn pages of a book?					
Play with puzzles with several interlocking pieces?					
Hold arms or legs up for dressing?					
Undress independently?					
Climb on and over objects?					
Jump with both feet together?					
Ride a tricycle while pedaling with feet?					
Build with blocks, Legos or other materials?					
Blow soap bubbles?					
Blow whistles?					
Initiate and zip without help?					
Tie shoes independently?					
Suck through a straw?					
Turn door handles independently?					
Blow nose independently?					
Brush teeth independently?					
Spit out toothpaste after brushing?					
Kick a ball?					
Button independently?					
Insist on dressing self?					
Ride a bicycle without training wheels?					
Complete snaps and buckles by self?					
Float on back and stomach in water?					
Open car doors by self?					
Jump rope?					
Blow a balloon?					
Blow bubbles with gum?					
Roller or ice skate well?					
Swim using crawl or other strokes?					

### Family History

Is there any family history of any of the following? If so, please state relationship (parent, grandparent, siblings, or others).

	Yes	No	Relationship to Child	Problem/Disorder
Left hand preference or ambidexterity?				
Learning problems?				
Behavior problems?				
Neurological or "nervous" disease (seizures, fits, weakness)?				
Medical disease such as diabetes, thyroid, heart, etc.?				
Mental illness such as schizophrenia, manic-depressive episodes, depression, ect.?				
Excessive use of drugs or alcohol?				
Trouble holding a job?				

## Speech-Language-Hearing

Do you feel your child has a speech problem?      Yes      No (if no, please skip this skip  
this section and conclude with additional comments)

If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you feel your child has a hearing problem?      Yes      No

If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has he/she ever had a speech evaluation/screening?      Yes      No

If yes, where and when? \_\_\_\_\_  
What were you told? \_\_\_\_\_  
\_\_\_\_\_

Has your child ever had speech therapy?      Yes      No

If yes, where and when? \_\_\_\_\_  
What was he/she working on? \_\_\_\_\_  
\_\_\_\_\_

Is your child aware of, or frustrated by, any speech/language difficulties? \_\_\_\_\_  
\_\_\_\_\_

What do you see as your child's most difficult problem in the home? \_\_\_\_\_  
\_\_\_\_\_

What do you see as your child's most difficult problem in school? \_\_\_\_\_  
\_\_\_\_\_

### Does your child,..

- repeat sounds, words or phrases over and over?
- understand what you are saying?
- retrieve/point to common objects upon request (ball, cup, shoe)?
- follow simple directions ("Shut the door" or "Get your shoes")?
- respond correctly to yes/no questions?
- respond correctly to who/what /where/when/why questions?

### Your child currently communicates using...

- body language.
- sounds (vowels, grunting).
- words (shoe, doggy, up).
- 2 to 4 word sentences.
- sentences longer than four words.
- other: \_\_\_\_\_

**Additional Comments**

Please feel free to add any additional information you may feel would assist me in getting to know and understand your child, especially your child's strengths and methods of coping. **Thank you again for taking the time to complete this form!!!**