INTEGRATED CHILDREN'S THERAPIES

where children make connections

DEVELOPMENTAL/SENSORY HISTORY

Ages 4 – 12 years

Parents: This history may appear to be quite long. However, a number of the questions require checking off responses, which can be done quickly. This information is very useful in gaining a clear understanding of your child's strengths and weaknesses. We appreciate your time.

Person Completing History: ☐Mother ☐ Father ☐ Self ☐ Other (specify) ___________________________

General Information:

Child's Full Name:_______________________________________ Birth Date:__________________

Address:____ Gender: male_____female_____

____ Phone #:____________________

Child's Race: ☐ Caucasian ☐ African Am. ☐Hispanic ☐Asian ☐Native Am. ☐Other (specify) ______________

Is child adopted? ☐Yes ☐No Foster Child? ☐Yes ☐No

Parents are: ☐married ☐separated ☐divorced ☐widowed ☐single ☐other (specify) _______________

Parent's Name:_________________________________ Relation to Child:_________________________

Occupation:____________________________________ Employer:________________________________

Phone #:

Parent's highest education completed: ☐less than high school ☐high school grad ☐some college/associates

☐bachelors ☐ post-graduate ☐doctoral/post-doctoral

Parent's Name:_________________________________ Relation to Child: _________________________

Occupation:____________________________________ Employer:________________________________

Phone #:

Parent's highest education completed: ☐less than high school ☐high school grad ☐some college/associates

☐bachelors ☐ post-graduate ☐doctoral/post-doctoral

Names and ages of brothers and sisters:____

Emergency Contact Person:____

(Name) (Relationship) (Phone #)

Teacher's Name:__________________________________School:_______________________________________

Grade in School:___________________Type of classroom:_______________________________________

Referred by (name, address, profession):____

Please provide child's **current**: Height: ________Weight: _______

Handedness (hand they use to write or eat): ☐ Right ☐ Left

Medical Information:

Child's Physician and other Professionals: (continue on back of page if needed)

Physician: ______________________ Address: ___________________________ Phone: ___________________

Other: _________________________ Profession: _________________________ Phone: ___________________

Other: _________________________ Profession: _________________________ Phone: ___________________

Other: _________________________ Profession: _________________________ Phone: ___________________

Medical Diagnosis:

_____ ADD/ADHD _____ Anxiety Disorder or Mood Disorder _______ Emotional Disorder

_____ Autism/PDD _____ Cognitive Delay _______ Down Syndrome

_____ Fragile X Syndrome _____ Learning Disabilities _______ Tourette's Syndrome

_____ Fractures ______Dislocations _______Muscle Strains

______ Joint Sprains _____ Non-Verbal Learning Disability _______Diabetes

_____ Other, specify: ____

Has child received previous evaluation and/or treatment by an occupational therapist?______________________

If yes, when and where:____

Has child had a vision test?____________ If yes, when?____

Has child had a hearing test?___________ If yes, when?____

What were the results of hearing and vision tests?____

Has your child had any of the following? If yes, describe and give approximate dates.

Childhood diseases or major illnesses:____

Congenital abnormalities:____

Surgery:____

Serious injury:____

Casts or braces:____

Ear infections:____

Tubes in ears:____

Allergies:____

Seizures:____

Other:____

List any medications your child is **currently** taking, its purpose and frequency of the dosage:

Medication: ______________________ Purpose: ________________________ Freq. of dosage: ______________

Medication: ______________________ Purpose: ________________________ Freq. of dosage: ______________

Medication: ______________________ Purpose: ________________________ Freq. of dosage: ______________

Medical information continued:

Has your child received medications **in the past** for any of the above-mentioned conditions?

Medication: ______________________ Purpose: ________________________ Dates Taken: _________________

Medication: ______________________ Purpose: ________________________ Dates Taken: _________________

Medication: ______________________ Purpose: ________________________ Dates Taken: _________________

Are there any medical **precautions** the therapist should be aware of when working with your child?

____

____

Does your child have any assistive devices (e.g., glasses, casts, equipment/orthotics)?______________________

____

Has your child received other evaluations or treatment (school, psychological, private therapist or clinic, neurology, nutritionist, GI consult, allergist, etc.)? If so, what type, when, and by whom?

Type Eval. Date Professional's Name Dates of therapy

____

____

____

____

____

What do you hope to gain from this evaluation and/or treatment?____

____

____

____

Mother's Health During Pregnancy:

Did the mother:

1) have any infections/illnesses during pregnancy? Yes_________No__________

Describe:____

2) have any shocks or unusual stresses during pregnancy? Yes_No_______________

Describe:____

3) receive any medication during pregnancy? Yes_________No__________

If yes, what kind:____

4) any complications during delivery/labor? Yes_________No__________

Describe:____

Child's Birth:

Was or did child:

1) full term Yes_____ No_______ Weight at birth:______________________

2) premature Yes_____ No_______ Number of weeks:___________________

3) breech (feet first) Yes_____ No________

4) require forceps for delivery: Yes_______ No________

5) require suction for delivery: Yes_______ No________

Child's Birth, continued:

6) have any birth injuries: Yes_______ No________

Describe:____

7) If known, Apgar score at one minute:____________ at five minutes:_________

8) require intensive care hospitalization: Yes__________ No_________

If yes, for how long?____

9) jaundiced? Yes_________ No_________ Length of treatment________________________

Infancy and Early Childhood:

Did your child:

1) have feeding problems? Yes_______ No_______ If yes, describe:____________

____

2) have sleeping problems? Yes_______ No_______ If yes, describe:____________

____

3) have colic? Yes_______ No_______ If yes, for how long?_________

4) prefer certain positions as an infant? Yes_______ No__________

If yes, describe:____

5) dislike lying on stomach? Yes________ No________

6) dislike lying on back? Yes________ No________

7) enjoy bouncing? Yes________ No________

8) become calmed by car rides or infant swings? Yes_______ No________

9) become nauseated by car rides or infant swings? Yes_______ No____

10) go through "terrible twos"? Yes_________ No_________

If no, describe your child's toddler stage:____

____

____

Developmental Milestones:

(Give approximate ages if remembered, or comment on anything unusual)

Rolling over______________ Walk_________________________ Say words___________________

Sit alone_________________ Chew solid food________________ Say sentences_______________

Crawl___________________ Drink from a cup_______________

Was crawling phase brief? ☐Yes ☐No Absent? ☐Yes ☐No

Did child use a walker (rolling plastic seat) or exer-saucer (stationary plastic seat)? ☐Yes ☐No

Experience hesitancy or delays in learning to go down stairs? ☐Yes ☐No

What concerns you most about your child?

Are there problems with any daily routines?

Please tell us about your child's strengths and gifts.

What in particular would you like your child to achieve?

How, if in any way, would you like to interact differently with your child?

Sensory History:

Please check the appropriate area, comment as desired, and cross out any parts of questions which do not apply to your child. Please refer to the scale below when answering.

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Visual-Spatial Processing:

	Does child:						Comments
1	become easily distracted by visual stimulation?	5	4	3	2	1	
2	dislike having eyes covered?	5	4	3	2	1	
3	like playing in the dark?	5	4	3	2	1	
4	tend to draw some numbers and letters backwards?	5	4	3	2	1	
5	blink at bright lights or seem irritated by them?	5	4	3	2	1	
6	have difficulty discriminating shapes, colors, etc.	5	4	3	2	1	
7	have trouble following objects with the eyes?	5	4	3	2	1	
8	avoid or have difficulty with eye contact?	5	4	3	2	1	

9 have a favorite color? ☐ Yes ☐ No What color(s)?________________________________

Is the child strongly attracted to this color? ☐Yes ☐No

Auditory and Language Processing:

	Does/is child:						Comments
1	like to sing or dance to music?	5	4	3	2	1	
2	have difficulty maintaining or copying rhythms?	5	4	3	2	1	
3	at times, seem not to understand what is said?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Auditory and Language Processing continued:

4	seem overly sensitive to sounds?	5	4	3	2	1	
5	become distracted by lots of noise?	5	4	3	2	1	
6	become distracted by background noises such as refrigerators, fluorescent lights, fans, etc.?	5	4	3	2	1	
7	seem to have trouble remembering what was said?	5	4	3	2	1	
8	have speech or articulation difficulties?	5	4	3	2	1	
9	have trouble expressing what he/she wants?	5	4	3	2	1	
10	unable to follow two or three directions given at once?	5	4	3	2	1	
11	misunderstand meaning of words in relation to movement or body position?	5	4	3	2	1	

Movement:

	Does child:						Comments
1	enjoy swings?	5	4	3	2	1	
2	seem to have good balance?	5	4	3	2	1	
3	enjoy merry-go-rounds or fast carnival rides?	5	4	3	2	1	
4	like being tipped upside down or lifted overhead?	5	4	3	2	1	
5	hesitate or avoid climbing on equipment such as jungle gyms?	5	4	3	2	1	
6	hesitate or have difficulty going down stairs?	5	4	3	2	1	
7	seem fearful of catching balls?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Movement continued:

8	dislike elevators or escalators?	5	4	3	2	1	
9	walk on toes?	5	4	3	2	1	
10	jump a lot on beds or other surfaces?	5	4	3	2	1	
11	bang head on purpose?	5	4	3	2	1	
12	rock in bed?	5	4	3	2	1	
13	tend not to alternate feet going down stairs? (4 years +)	5	4	3	2	1	
14	like to spin self around?	5	4	3	2	1	
15	become carsick easily?	5	4	3	2	1	
16	become upset if head is tilted backwards as in hair washing?	5	4	3	2	1	

Taste and Smell:

	Does child:						Comments
1	tend to explore with smell, deliberately smell objects?	5	4	3	2	1	
2	react defensively or seem overly sensitive to some odors?	5	4	3	2	1	
3	react defensively to the taste and texture of many foods?	5	4	3	2	1	
4	act as though all food tastes the same?	5	4	3	2	1	
5	have more difficulty eating textured than smooth foods?	5	4	3	2	1	
6	prefer crunchy textured foods?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Taste and Smell continued:

7	have difficulty eating smooth foods with a few lumps (i.e. soup)?	5	4	3	2	1	
8	lick, suck or chew on non-food items (18 months +)? What items? (write in "comments")	5	4	3	2	1	

9 What foods does the child prefer?____

____

Touch (Tactile Processing):

	Does child:						Comments
1	seem excessively ticklish?	5	4	3	2	1	
2	become irritated by tags in the back of shirts?	5	4	3	2	1	
3	prefer to touch rather than be touched?	5	4	3	2	1	
4	strongly dislike haircutting or shampooing?	5	4	3	2	1	
5	dislike fingernail or toenail cutting?	5	4	3	2	1	
6	tend to examine objects by touching thoroughly with hands? (2 years +)	5	4	3	2	1	
7	have difficulty petting animals, may use too much force?	5	4	3	2	1	
8	complains if socks aren't on correctly?	5	4	3	2	1	
9	seem to crave being held and cuddled?	5	4	3	2	1	
10	dislike being touched unexpectedly?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Touch (Tactile Processing) continued:

11	tend to prefer long sleeves and pants regardless of weather?	5	4	3	2	1	
12	dislike cloth of certain textures?	5	4	3	2	1	
13	avoid getting hands into paste, finger paints, or messy things?	5	4	3	2	1	
14	often seem overly active?	5	4	3	2	1	
15	tend to bump or push others?	5	4	3	2	1	
16	tend to be more sensitive to pain than others?	5	4	3	2	1	
17	become especially bothered by small cuts?	5	4	3	2	1	
18	tend not to feel pain as much as others?	5	4	3	2	1	
19	seem oblivious to bruises and heavy falls?	5	4	3	2	1	
20	tend to remove shoes whenever possible?	5	4	3	2	1	
21	complain that others often hit or push him or her?	5	4	3	2	1	
22	pinch, bite or otherwise hurt self?	5	4	3	2	1	
23	complain about irritating bumps on the bed sheets?	5	4	3	2	1	
24	over or under-dress for the temperature?	5	4	3	2	1	
25	overheat easily?	5	4	3	2	1	
26	strongly dislike showers (if over age five)?	5	4	3	2	1	
27	become extremely irritated when splashed with water?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Touch (Tactile Processing) continued:

28	mouth objects or clothing frequently?	5	4	3	2	1	
29	seem overly sensitive to food or water temperature?	5	4	3	2	1	

Social:

	Does child:						Comments
1	make friends easily?	5	4	3	2	1	
2	tend to prefer to play alone?	5	4	3	2	1	
3	have a strong desire for sameness and routine?	5	4	3	2	1	
4	tend to crave attention?	5	4	3	2	1	
5	seem sensitive to criticism?	5	4	3	2	1	
6	lack self-confidence?	5	4	3	2	1	
7	have strong outbursts of anger, tantrums?	5	4	3	2	1	
8	have trouble getting along with other children?	5	4	3	2	1	
9	tend to be active and aggressive?	5	4	3	2	1	
10	tend to be quiet and withdrawn?	5	4	3	2	1	
11	tend to lack carefulness, be impulsive?	5	4	3	2	1	
12	tend to be relaxed and patient?	5	4	3	2	1	
13	tend to be intense, easily frustrated?	5	4	3	2	1	
14	tend to be in perpetual motion?	5	4	3	2	1	
15	tend to have difficulty separating from parents?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Social continued:

16	tend to be very set in her or his routines?	5	4	3	2	1	
17	prefer the company of adults to children?	5	4	3	2	1	
18	prefer playing with children who are 1 to 2 years younger?	5	4	3	2	1	
19	seem discouraged or depressed?	5	4	3	2	1	

Motor Skills:

	Does child:						Comments
1	bump into things frequently?	5	4	3	2	1	
2	have difficulty with motor tasks that have several steps?	5	4	3	2	1	
3	have an awkward grasp with a pencil or crayon?	5	4	3	2	1	
4	have poor handwriting?	5	4	3	2	1	
5	grimace or move tongue while doing fine motor tasks?	5	4	3	2	1	
6	seem shaky when doing fine or gross motor tasks?	5	4	3	2	1	
7	seem weaker than others his or her age?	5	4	3	2	1	
8	frequently grasp objects very tightly?	5	4	3	2	1	
9	tend to break many objects?	5	4	3	2	1	
10	drop things easily?	5	4	3	2	1	
11	tire easily with physical activity?	5	4	3	2	1	
12	seem to deliberately fall or tumble?	5	4	3	2	1	

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Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Motor Skills continued:

13	tend to eat in a sloppy manner?	5	4	3	2	1	
14	find small manipulative activities difficult?	5	4	3	2	1	
15	prefer playground to table activities?	5	4	3	2	1	
16	prefer table activities to playground activities?	5	4	3	2	1	
17	perform movements in a slow and plodding fashion?	5	4	3	2	1	
18	take a long time to do most motor tasks?	5	4	3	2	1	
19	appear reluctant to participate in sports and games?	5	4	3	2	1	
20	tend to move in and out of chair while eating or doing work?	5	4	3	2	1	
21	feel heavier when lifted than anticipated?	5	4	3	2	1	
22	have flat feet?	5	4	3	2	1	
23	slump while sitting?	5	4	3	2	1	
24	have difficulty with handling eating utensils?	5	4	3	2	1	
25	frequently spill liquids?	5	4	3	2	1	
26	drool?	5	4	3	2	1	
27	keep mouth open most of the time?	5	4	3	2	1	
28	have trouble chewing?	5	4	3	2	1	
29	tend to be slow in dressing?	5	4	3	2	1	
30	tend to be slow in eating?	5	4	3	2	1	

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Bowel and Bladder:

Does or did child:

1) have trouble learning urinary control? ☐Yes ☐No

2) have trouble learning bowel control? ☐Yes ☐No

3) continue to have accidents during the day until age__________

4) continue to have accidents during the night until age_________

5) seem to have difficulty registering the need to eliminate? ☐Yes ☐No

Sleep Patterns:

Does child:

1) have regular sleep patterns? ☐Yes ☐No If no, describe:____

____

2) wake frequently during the night? ☐Yes ☐No If yes, describe:____

____

3) tend to be an early riser, up and on the go? ☐Yes ☐No

4) have a difficult time falling asleep? ☐Yes ☐No

Play Skills:

1) What are your child's favorite play things?____

____

2) What does she or he do with these toys?____

____

3) Who does child prefer to play with?____

____

4) What activities does the child least enjoy?____

5) Are there any things that your child tends to fear or avoid? ☐Yes ☐ No

If yes, describe:____

6) How long does child play with one toy?____

7) Does your child tend to play while in one position more than others do? ☐Yes ☐No

If yes, what position?____

8) Does your child tend to play with things by lining them or piling them up (if over two years of age)?

☐Yes ☐No Describe:____

9) What extra-curricular activities is your child involved in (i.e., gymnastics, swimming lessons, Scouts, etc.)?

____

____

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School Skills:

If enrolled in school, is your child considered to have difficulty in any of the following? (Check those that apply.)

☐Reading ☐Math ☐Following Directions

☐Handwriting ☐Spelling ☐Finishing tasks

☐Paying attention ☐Restlessness ☐Organizing work

☐Remembering Information

Other:____

1) What are your child's favorite subjects in school?__________________________________

2) What are your child's least favorite subjects?_____________________________________

Developmental Skills (please circle those items in a specific category that your child can not do):

(some skills not expected until 8-10 years) Ease of Performance:

	Can your child:	No	Yes	Some difficulty	Average	Good
1	turn pages of a book?					
2	play with puzzles with single pieces?					
3	play with puzzles with several interlocking pieces?					
4	hold arms or legs up for dressing?					
5	undress self independently?					
6	climb on and over objects?					
7	jump with both feet together?					
8	ride a tricycle or big wheel while pedaling with the feet?					
9	build with blocks, Lego's, or other materials?					
10	blow soap bubbles?					
11	blow whistles?					
12	suck through a straw?					
13	draw lines and circles?					
14	turn door handles independently?					
15	pump self on a swing?					
16	blow nose independently?					
17	spit out toothpaste after brushing?					
18	kick a ball?					
19	catch a ball?					

Developmental Skills (please circle those items in a specific category that your child can not do):

(some skills not expected until 8-10 years) Ease of Performance:

	Can your child:	No	Yes	Some difficulty	Average	Good
19	wipe self after toileting?					
20	hop on one foot?					
21	color inside lines?					
22	manipulate buttons independently?					
23	dress self independently? (underwear, socks, shoes, shirt, pants, coat/sweater)					
24	insist on dressing self?					
25	cut with scissors?					
26	ride a bicycle with training wheels?					
27	ride a bicycle without training wheels?					
28	tie shoes?					
29	manipulate zippers, snaps, buckles independently?					
30	skip with both feet?					
31	float on back and stomach in the water?					
32	open car doors independently?					
33	use spoon, fork?					
34	cut with a knife?					
35	jump rope?					
36	blow a balloon?					
37	blow bubbles with gum?					
38	snap fingers?					
39	roller or ice skate fluidly?					
40	swim using the crawl or other strokes?					

Do you or anyone else in your family have similar difficulties to your child's? If so, please describe below and/or mark pertinent sections of the questionnaire in a second color. If similar difficulties do exist, how have they affected your life or the lives of other family members? (Attach an additional page if desired.)

Signature Date