



INTEGRATED CHILDREN'S THERAPIES

where children make connections



DEVELOPMENTAL HISTORY

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

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Occupation: _____ Employer: _____

Phone #:

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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 a physical 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: _____

Tingling Numbness or Loss of Feeling: _____

Other (headaches/falls): _____

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

Medication: _____ Purpose: _____ Freq. of dosage: _____

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Medication: _____ Purpose: _____ Freq. of dosage: _____

Medical information continued:

Place an X in the appropriate box if any of these diagnostic tests have been performed.

	TEST	DATE	RESULTS
	X-Ray		
	MRI		
	CAT Scan		
	EMG/NCV		
	Bone Scan		

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., 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
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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) Birth: Vaginal _____ C-Section _____ Breech (feet first) _____
- 4) require forceps for delivery: Yes _____ No _____
- 5) require suction for delivery: Yes _____ No _____
- 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

If yes, how often and for how long? _____

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?

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

Balance or Vestibular Processing:

	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	
8	walk on toes?	5	4	3	2	1	
9	tend not to alternate feet going down stairs? (4 years +)	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	

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

Social continued:

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	
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	grimace or move tongue while doing gross motor tasks?	5	4	3	2	1	

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

Motor Skills Continued:

4	seem shaky when doing gross motor tasks?	5	4	3	2	1	
5	seem weaker than others his or her age?	5	4	3	2	1	
6	frequently grasp objects very tightly?	5	4	3	2	1	
7	tend to break many objects?	5	4	3	2	1	
8	drop things easily?	5	4	3	2	1	
9	tire easily with physical activity?	5	4	3	2	1	
10	seem to deliberately fall or tumble?	5	4	3	2	1	
11	perform movements in a slow and plodding fashion?	5	4	3	2	1	
12	take a long time to do most motor tasks?	5	4	3	2	1	
13	appear reluctant to participate in sports and games?	5	4	3	2	1	
14	feel heavier when lifted than anticipated?	5	4	3	2	1	
15	have flat feet?	5	4	3	2	1	
16	slump while sitting?	5	4	3	2	1	
17	keep mouth open most of the time?	5	4	3	2	1	

Play Skills:

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

2) What activities does the child least enjoy? _____

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

If yes, describe: _____

Play Skills Continued:

- 4) Does your child tend to play while in one position more than others do? Yes No
 If yes, what position? _____
- 5) What extra-curricular activities is your child involved in (i.e., gymnastics, swimming lessons, Scouts, etc.)?

Developmental Skills:

(some skills not expected until 8-10 years)

Ease of Performance:

1	Can your child:	No	Yes	Some difficulty	Average	Good
2	climb on and over objects?					
3	jump with both feet together?					
4	ride a tricycle or big wheel while pedaling with feet?					
5	pump self on a swing?					
6	kick a ball?					
7	hop on one foot?					
8	ride a bicycle with training wheels?					
9	ride a bicycle without training wheels?					
10	skip with both feet?					
11	jump rope?					
12	roller or ice skate fluidly?					
13	swim using the crawl or other strokes?					

Pain Scale:

Place an X in the box(es) that best describe your child's pain.

<input type="checkbox"/>	Constant	<input type="checkbox"/>	Increasing	<input type="checkbox"/>	Night Pain	<input type="checkbox"/>	Dull/Achy Pain
<input type="checkbox"/>	Intermittent	<input type="checkbox"/>	Decreasing	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	Pain Upon Walking
<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Static	<input type="checkbox"/>	Sharp Pain	<input type="checkbox"/>	After Standing or walking too long
Pain is aggravated by:							
Pain is eased by:							

Signature

Date

