

Development is CHILD'S PLAY!

AN EVALUATION AND TREATMENT CLINIC FOR CHILDREN NEEDING EXTRA HELP

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DEVELOPMENTAL HISTORY FOR INFANTS

Child's Name: _____ Date of Birth: _____ Age (adjusted): _____ Sex: M/F

Name of person completing form: _____ Date: _____

Birth History

Are you your child's birth/step/adoptive parent?

If you are not the birth parent:

- At what age did your child come into your care?
- Describe pre- and post-natal environments (e.g., institution):

Please provide information about any problems with pregnancy, labor, or delivery:

Full Term or Premature? _____ If premature, #weeks early _____ Birth weight _____

Any problems during labor or delivery?

Neonatal:

___ oxygen required _____ jaundice _____ NICU: length of stay _____
___ difficulty nursing/poor suck _____ excessively sleepy
___ difficulty regulating temperature _____ medical intervention needed; specify:
___ other:

Medical History

Please indicate all that are applicable and age(s):

___ high fevers _____ meningitis _____ ear infections
___ heart trouble _____ excessive vomiting _____ poor weight gain
___ seizures _____ lung/bronchial difficulties _____ orthopedic issues
___ epilepsy _____ surgery/hospitalization (explain):

Other significant history, accident, injury, or illness?

Please list any previous medical and/or diagnostic tests or evaluations (e.g., physical, neurological, developmental) and their results. If possible, please attach reports.

Any diagnosis given: _____ Does child have a visual or hearing problem? _____

Are there any physical or medical precautions or activity restrictions (i.e., due to heart problems, asthma, seizures, physical limitations, etc.)?

Is your child currently on any medication? No _____ Yes _____

Purpose:

Please check if your child has received services from any of the following:

___ occupational therapy ___ physical therapy ___ feeding/lactation ___ Early Start

Developmental Milestones

Were feeding and sleeping patterns easily established?

Fussy baby past 6 months of age? Any reason identified?

Indicate child's age for achieving the following. If unsure, note early, late, typical, not yet:

____ roll front to back ____ roll back to front ____ independent sitting
 ____ move in/out of sitting ____ hands/knees crawling ____ pull to stand

Does your child tolerate tummy time? How long?

If your child moves around, but does not crawl on hands and knees, explain how child moves:

Feeding (check any that apply):

____ Breast milk or formula ONLY

____ Finger foods, list:

____ Pureed foods (1st infant foods)

____ G/NG tube

____ Mashed fruits and vegetables

How does child react to new foods?

Does child have any food restrictions/sensitivities?

Does child gag or cough during or just after eating?

Does child have reflux, excess spit up or vomiting during or just after eating?

Sleeping

How long does child sleep at night?

Is child able to fall back to sleep on own if awakens at night?

Does child snore?

Describe your child's sleeping arrangement (e.g., own crib, family bed):

Is this the arrangement you would like to continue?

Social/Communication (check any that apply):

____ Easily calmed What calms child?

____ Usually happy

____ Raises arms to be picked up

____ Recognizes his/her name

____ Likes being held

____ Enjoys peek-a-boo games

____ Objects to bath time

____ Tolerates diaper change without upset

____ Difficulty being tilted back to rinse hair

How does your child communicate with you?

Current areas of concern, if any (please mark all that apply):

____ gross motor development ____ language/communication ____ sleeping

____ fine motor development ____ social skills ____ play skills

____ feeding/eating ____ temperament ____ other:

Explain concerns:

When did you first notice your child's difficulties and how were they apparent to you?

Anything more that you'd like us to know about your child, your child's development, or your interactions with your child?