Development is CHILD'S PLAY!
Where Fun and Function Go Hand-in-Hand

YOUNG CHILD SENSORIMOTOR HISTORY

Child's Name: ________________________________ Date of Birth: _______ Age: ______ Sex: M/F

Name of person completing form: ____________________________________ Date: ______________
Are there any physical or medical precautions or activity restrictions (e.g., due to heart problems, asthma, seizures, physical limitations, etc.)?

Is your child currently on any medication? No _____ Yes _____ Purpose: _________________________
Names of medication, dosage, side effects:

Please specify significant allergies or food restrictions and note if current or previous:

Pregnancy and Birth History

Are you your child's birth/step/adoptive parent?
If not the birth parent:
Pre- and post-natal environments (e.g., institution)?
At what age did your child come into your care?

Problems / difficulties during pregnancy:
___ bleeding ___ toxemia ___ diabetes ___ severe nausea
___ emotional stress ___ infection ___ premature labor ___ other:
How was it treated?

Labor / Delivery:
Full-term or premature? ___________________ Gestational age: ____________ Birth weight: ________
___ fetal monitor ___ forceps ___ vacuum extraction ___ C-section
___ water broke > 24 hours before delivery ___ cord around neck ___ breech
___ meconium aspirated ___ birth injuries ___ delayed cry ___ limpness
___ other:

Neonatal:
___ oxygen required ___ jaundice ___ NICU: length of stay __________
___ difficulty nursing/poor suck ___ irritable
___ difficulty regulating temperature ___ medical intervention needed; specify:
___ other:

Developmental Milestones:

Were feeding and sleeping patterns easily established?
Fussy baby past 6 months of age? Any reason identified?
At what age did your child consistently sleep through the night?
Indicate child's age for achieving the following skills. If uncertain, indicate early, late, or typical:
_____ independent sitting _____ hands/knees crawling _____ walking
_____ first words _____ sentences _____ toilet trained ______ ______
day night

Do you think that any part of your child's development is slower than average?
If yes, explain:

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

___ Gross Motor Development ___ Fine Motor Development ___ Sleeping
___ Language Development ___ Social Skills ___ Eating
___ Play Skills ___ Temperament ___ Attention/Focus
___ Frustrations (list):
___ Fears (list):
___ Other:

Explain concerns:

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

Is there a family history of similar difficulties? If so, who, and what are the difficulties?

Please list any previous medical and/or diagnostic tests or evaluations (e.g., neurological, educational, speech/language, developmental, other) and their results. If possible, please attach copies of reports.

Significant test results:

Any diagnosis given:

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

___ Occupational Therapy ___ Physical Therapy ___ Speech Therapy
___ Tutoring ___ Psychological Counseling ___ Special Education

If so, when, where (private or school), and for how long?

Are these services ongoing?

Medical and Behavioral History

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

_____ High fevers _____ Meningitis _____ Ear infections / tubes
_____ Heart trouble _____ Excessive vomiting
_____ Seizures __/__ Lung / bronchial difficulties
_____ Epilepsy _____ Diabetes _____ Surgery / hospitalization

Other significant accident, injury, or illness?

Mark with a "C" if this is a Current behavior or "P" if it is a behavior previously demonstrated.

_____ Drools excessively _____ Resists being held _____ Likes to cuddle
_____ Easy to manage _____ Tenses when held _____ Likes being held
_____ Very active _____ Cries, fussy, irritable _____ Distractible
_____ Good sleep patterns _____ Tantrums/meltdowns _____ Quiet or passive

Comments:

Does your child use a transitional object or security toy (bear, blanket, pacifier)?

What are your child's most preferred activities?
Indoors:

Outdoors:

What are your child's least favorite activities?
Indoors:

Outdoors:

When is your child most calm or happy?

When does your child become most frustrated?

Does your child tend to have difficulty learning new motor tasks/games?

Does your child resist participating in fine or gross motor tasks? Please explain:

Does your child have any recently acquired skills?

Check the following items that best describe your child. If it was true for your child in the past but not currently, please put a "P" rather than a check mark.

Visual

____ Wears glasses
____ Has a diagnosed visual problem (describe):
____ Has difficulty finding / seeing things (shoes in the closet, toy in a toy basket)

Auditory and Language

____ Has a suspected or diagnosed hearing loss
____ Limited or absence of gesturing to assist communication
____ Excessive talking interferes with listening
____ Nonverbal; Does s/he have a form of communication? List/circle the form of communication system (PECS, Sign Language, gestures used, etc.)

If language is not strong, describe the vocalizations your child uses to communicate.

Are there certain noises that your child cannot tolerate? If so, please give examples.

Oral-Motor and Respiratory Control

____ Displays poor lip control / lip closure for eating, drinking, using utensils
____ Has limited skills with blow toys, whistles, bubbles
____ Demonstrates poor saliva control (drools)
____ Chokes easily on liquids or solids. Specify:
____ Overstuffs mouth with food
____ Clenches jaw or grinds teeth
____ Holds breath frequently
____ Breathes with mouth open / often has mouth open/noisy breathing
____ Snores

Does your child tend to gag or cough during or just after eating? If so, is it frequent?
Does your child have difficulty chewing different types of foods? If so, which types?
Comments:

Daily Routines

DRESSING

Is your child able to: (Check those which your child CAN do, circle if options)

__ Dress/Undress
__ Button/Unbutton
__ Snap/Unsnap
__ Socks on/off
__ Jacket on/off
__ Shoes on/off
__ Zippers pull/engage/disengage
__ Notice when clothes are backwards, twisted, wet, or fasteners undone

Please describe how your child typically gets dressed. Include how much assistance is needed or how independent your child is with clothing, your child's behavior during dressing, and if there are types of clothing your child will not wear.

HYGIENE/GROOMING

Is your child able to:

__ Allow an adult to wipe his/her face, brush teeth, brush/style hair
__ Allow an adult to wash his/her hair
__ Allow adult to clip nails
__ Allow adult to cut hair
__ Wash and dry hands at home

Please describe a typical bath time for your child. Include your child's like or dislike for bath time, your child's behavior during bath time, level of assistance needed, etc.

TOILETING

Is your child able to :

__ Wipe effectively
__ Manage clothes for toileting
__ Get to toilet without reminders
__ Wash and dry hands in a public restroom (Use varied faucets, towel dispensers, air dryers)

Do the noises in a public restroom (flushing toilets, air dryers) interfere with your child using one?

If your child has difficulty with controlling bowel and / or bladder (day or night or both), please explain:

EATING

Is your child able to:

__ Remain seated for a family meal for 10 minutes (If not, how long can your child last? ___________)
__ Eat liquid foods (such as soup or cereal with milk) without spilling (If not, what % is spilled? _____)
__ Use eating utensils for majority of foods
__ Drink from a lidded (sippy) cup
__ Drink from an open cup
__ Drink from a straw
__ Spread with a knife (such as jam, cream cheese, or peanut butter)
__ Pour liquid into a glass without spilling
__ Open a variety of food storage containers (e.g.: zip-lock bags, snap lid, screw top)

Is your child what you would describe as a "picky eater"? If so, please describe the foods your child will eat or those s/he won't eat (whichever is easier for you):

Are there foods that your family typically eats that your child will not?

Please describe a typical mealtime with your child. Include where, what and with whom your child eats, your child's typical appetite, the number of meals and snacks your child has each day, and your child's behavior

during mealtimes. Include any concerns related to limited or unhealthy diet, managing foods which are more difficult to chew, difficulty with specific types of food/textures, and tolerance of mixed textured food.

What does your child usually eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

SLEEPING

Is your child able to:

__ Get himself/herself to sleep (vs. falling asleep while adult is present)
__ Sleep in own bed
__ Sleep through the night
__ Get self back to sleep if wakes up in the night
__ Awaken on own in the morning

How many hours/night does your child usually sleep?
How long does it usually take for your child to fall asleep?
Does your child have a prolonged bedtime routine?
Does your child nap/fall asleep in the daytime? If so, for how long?
Are you able to get adequate sleep? If not, what are the disruptions?

Temperament/Social

1. Does your child seem irritable at predictable times of the day? If yes, please describe the times of the day when your child seems irritable and the events that seem likely to trigger irritability.

2. Does your child seem happier or more cooperative at predictable times of the day? If yes, please describe the times of the day when your child seems happiest and most cooperative, and the events that seem likely to precede these behaviors.

3. Can your child independently settle down after periods of exciting activity or after being upset? If not, what strategies can be helpful?

4. Please describe how your child approaches and explores a new environment.

5. Does your child exhibit any repetitive, idiosyncratic, or self-stimulating patterns of behavior? If so, please describe behavior and typical situation in which it may occur.

6. Please describe your child's typical play skills. Describe your child's interaction with other children. Include information about the ages of people your child chooses to play with (same age, older, younger, only adults), if your child chooses to be a leader, a follower, or an independent player, and how many people your child is comfortable playing with at a time. What are peers' reactions to your child?

Family Resources

The family plays a primary role in developing a child's potential. This information will help us support your child's performance across environments.

Please list:

Names and ages of everyone living in the home:

Any health concerns in the family:

Others who can help care for your child or implement supplemental therapy activities (e.g., extended family, sitters, ABA providers, etc.):

Given your needs and those of your family, how much time/energy do you and others have available to work with your child on areas of concern (e.g., none, 1 hr./day; 2x/week, etc.)?

Are you satisfied with the level of support available to you?

On a scale of 1-10, with 1 being "not stressful" to 10 being "extremely stressful", please rate your current level of stress.

What changes would make a positive difference in your family's quality of life?

Are there family circumstances or culturally based issues that may be important for us to consider?

Summary

What things do you enjoy most about your child?

What are your main concerns about your child?

In what areas of your child's everyday functioning (dressing, eating, sleeping, hygiene, etc.) do you most want to have help?

What are the first 3 skills that you would like to see your child achieve in OT?

1.

2.

3.

Please provide any other information that you would like to share about your child.

Thank you for your time and your thoughtful responses.