

**Therapy Zone 4 Kidz**  
17705 Hale Ave. Suite C-4  
Morgan Hill, Ca. 95037

**DEVELOPMENTAL HISTORY AND BACKGROUND**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Please check the column which best describes your child. After each item and category, please write any remarks or comments that you feel may be helpful. Please include child's strengths in comment area.

**BEFORE BIRTH:**

**YES    NO    REMARKS**

- |  |     |     |       |
|--|-----|-----|-------|
| 1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operation or any other difficulties? | ___ | ___ | _____ |
| 2. Were any drugs or medications taken during pregnancy? Specify.  | ___ | ___ | _____ |

**DELIVERY:**

- |   |     |     |       |
|---|-----|-----|-------|
| 1. Was the pregnancy full term?                             | ___ | ___ | _____ |
| 2. Was the pregnancy premature?                             | ___ | ___ | _____ |
| 3. Was it an unusual delivery? (Breech, Caesarean, specify) | ___ | ___ | _____ |
| 4. Was the labor normal?                                    | ___ | ___ | _____ |
| 5. Was the labor abnormal? (Prolonged, short, specify)      | ___ | ___ | _____ |
| 6. Were forceps used?                                       | ___ | ___ | _____ |
| 7. Was medication given during delivery? Specify.           | ___ | ___ | _____ |

**BIRTH:**

- |  |     |     |       |
|--|-----|-----|-------|
| 1. Was your child considered to be a low birth weight? Specify | ___ | ___ | _____ |
| 2. Were there complications such as                            | ___ | ___ | _____ |
| <b>a.</b> Cyanosis   | ___ | ___ | _____ |
| <b>b.</b> Jaundice   | ___ | ___ | _____ |
| <b>c.</b> Congenital defects                                   | ___ | ___ | _____ |
| <b>d.</b> Limpness   | ___ | ___ | _____ |
| 3. Was there a need for:                                       |     |     |       |
| <b>a.</b> Oxygen   | ___ | ___ | _____ |
| <b>b.</b> Transfusion  | ___ | ___ | _____ |
| <b>c.</b> Tube feedings  | ___ | ___ | _____ |
| 4. Were there any feeding difficulties? Specify                | ___ | ___ | _____ |
| 5. Was the child bottle fed?                                   | ___ | ___ | _____ |
| 6. Was the child breast fed?                                   | ___ | ___ | _____ |
| 7. Did the child have problems sucking?                        | ___ | ___ | _____ |

**MEDICAL HISTORY:**

	<b><u>YES</u></b>	<b><u>NO</u></b>	<b><u>SOMETIMES</u></b>
1. Has your child had any of the following:			
<b>a.</b> Meningitis	---	---	_____
<b>b.</b> Measles	---	---	_____
<b>c.</b> Chicken pox	---	---	_____
<b>d.</b> High fevers	---	---	_____
<b>e.</b> Mumps	---	---	_____
<b>f.</b> Whooping cough	---	---	_____
<b>g.</b> Scarlet fever	---	---	_____
<b>h.</b> Convulsions	---	---	_____
<b>i.</b> Diabetes	---	---	_____
<b>j.</b> Lung or bronchial difficulties	---	---	_____
<b>k.</b> Heart trouble	---	---	_____
<b>l.</b> Seizures (indicate when, how often)	---	---	_____
<b>m.</b> Allergies	---	---	_____
<b>n.</b> Excessive vomiting	---	---	_____
<b>o.</b> Tuberculosis	---	---	_____
<b>p.</b> Polio	---	---	_____
<b>q.</b> Physical injuries (if yes, describe)	---	---	_____
2. Does your child have a vision problem?	---	---	_____
3. Has your child had an eye evaluation? Date of Exam _____	---	---	_____
4. Does your child have a hearing problem?	---	---	_____
5. Has your child had a hearing evaluation? Date of Exam _____	---	---	_____
6. Is your child currently on medication? If yes, give a list and state reasons	---	---	_____

**DEVELOPMENTAL HISTORY:**

	<b><u>AGE</u></b>		
1. At what age did your child: (please specify ages as near as possible)			
<b>a.</b> Roll over both ways?			_____
<b>b.</b> Sit alone?			_____
<b>c.</b> Walk?			_____
<b>d.</b> Speak his first word (what was it)?			_____
<b>e.</b> Speak his first sentence (what was it)?			_____
<b>f.</b> Drink from a cup independently?			_____
<b>g.</b> Use a spoon independently?			_____
<b>h.</b> Feed himself independently?			_____
2. Describe your child as an infant			
<b>a.</b> Cries often, fussy, irritable	<b><u>YES</u></b>	<b><u>NO</u></b>	<b><u>SOMETIMES</u></b>
<b>b.</b> Is good, non-demanding	---	---	---
<b>c.</b> Is alert	---	---	---
<b>d.</b> Is quiet	---	---	---
<b>e.</b> Is passive	---	---	---
<b>f.</b> Is active	---	---	---

	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
<b>g.</b> Likes being held	—	—	—
<b>h.</b> Resists being held	—	—	—
<b>i.</b> Is floppy when held	—	—	—
<b>j.</b> Is tense when held	—	—	—
<b>k.</b> Has good sleep patterns	—	—	—
<b>l.</b> Has irregular sleep patterns	—	—	—
3. Describe your child at present			
<b>a.</b> Is mostly quiet	—	—	—
<b>b.</b> Is overly active	—	—	—
<b>c.</b> Tires easily	—	—	—
<b>d.</b> Talks constantly	—	—	—
<b>e.</b> Too impulsive	—	—	—
<b>f.</b> Is restless	—	—	—
<b>g.</b> Is stubborn	—	—	—
<b>h.</b> Is resistant to changes over reacts	—	—	—
<b>i.</b> Fights frequently	—	—	—
<b>j.</b> Is usually happy	—	—	—
<b>k.</b> Exhibits frequent temper tantrums	—	—	—
<b>l.</b> Is clumsy has difficulty separating from primary caretaker	—	—	—
<b>m.</b> Has nervous habits or tics	—	—	—
<b>n.</b> Falls often has poor attention span	—	—	—
<b>o.</b> Is frustrated easily	—	—	—
<b>p.</b> Has unusual fears	—	—	—
<b>q.</b> Rocks self frequently	—	—	—
<b>r.</b> Has difficulty learning new tasks (i.e., using a toy)	—	—	—

Language:

- |  |   |   |   |
|--|---|---|---|
| 1. Does your child seem to understand what is said to him? | — | — | — |
| 2. Did your child start to talk and then stopped?          | — | — | — |

**SENSORY HISTORY:**Auditory:

Does your child

- |   |   |   |   |
|---|---|---|---|
| 1. Respond negatively to unexpected or loud noises?                     | — | — | — |
| 2. Have difficulty paying attention when there are other noises nearby? | — | — | — |
| 3. Miss hearing some sounds?  | — | — | — |
| 4. Seem confused as to the direction of sounds:                         | — | — | — |
| 5. Seem to enjoy strange noises and/or make loud noises:                | — | — | — |
| 6. Appear to be hard of hearing”  | — | — | — |
| 7. Enjoy music”   | — | — | — |
| 8. Have a diagnosed hearing loss?                                       | — | — | — |

Gustatory-Olfactory-Elimination:

Does your child

- |  |   |   |   |
|--|---|---|---|
| 1. Act as though all food tastes the same? | — | — | — |
| 2. Chew on non-food objects?               | — | — | — |

	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
3. Have unusual cravings for certain foods:	___	___	___
4. Dislike food of certain texture?	___	___	___
5. Explore by smelling?	___	___	___
6. Discriminate odors?	___	___	___
7. React negatively to smell?	___	___	___
8. Ignore unpleasant odors?	___	___	___
9. Have trouble with constipation?	___	___	___

Visual:

Does your child

1. Appear happier in the dark?	___	___	___
2. Pick up pictures or objects and look very closely and carefully at them?	___	___	___
3. Resist having eyes covered?	___	___	___
4. Becomes excited when there are a variety of visual objects?	___	___	___
5. Squints often?	___	___	___
6. Have difficulty with visually focusing on things far away?	___	___	___
7. Have difficulty with visually focusing on things close?	___	___	___

Tactile:

Does your child

1. Avoid playing with "messy" things, i.e., finger paint, paste, mud, sand, etc.	___	___	___
2. Dislike having his face washed or wiped?	___	___	___
3. Appear to be irritated by cloth of certain textures? Specify.	___	___	___
4. Object to being touched?	___	___	___
5. Dislike being touched unexpectedly?	___	___	___
6. Dislike being cuddled?	___	___	___
7. Prefer to touch rather than be touched?	___	___	___
8. Avoid using hands for extended periods?	___	___	___
9. Bang his head on purpose now or in the past?	___	___	___
10. Pinch, bite or otherwise hurt himself?	___	___	___
11. Examine objects by putting them into his mouth?	___	___	___
12. Tend to feel less pain than others?	___	___	___
13. Tend to feel pain more than others?	___	___	___

Motor:

Can your child

1. Hop on one foot	___	___	___
2. Skip	___	___	___
3. Jump with both feet together?	___	___	___
4. Ride a tricycle?	___	___	___
5. Ride a two wheeler with or without training wheels/	___	___	___
6. Pump self on the swing?	___	___	___
7. Kick a ball?	___	___	___

**YES**    **NO**    **SOMETIMES**

Does your child exhibit difficulty with

1. Cutting or pasting
2. Small manipulative toys?
3. Learning to hold a pencil or crayon with a 3 finger grasp?
4. Learning how to use playground equipment?

___	___	___
___	___	___
___	___	___
___	___	___

Comments:

**Social Adjustment:**

Does your child

1. Find it hard to make friends among his peers?
2. Prefer the company of adults, or older children?
3. Prefer to play with younger children?
4. Frequently express feeling of failure or frustration?
5. Play with toys appropriate for his age?

___	___	___
___	___	___
___	___	___
___	___	___
___	___	___

Comment:

**School Performance:**

1. Does your child:
2. Need to prop his head in his or her hand while reading or writing at the desk?
3. Mix up which hand or foot is left or right?
4. Know which hand is dominant?
5. Make reversals of letter or numbers when writing?
6. Read words in reverse?
7. Finds PE or sports to be a difficult experience?
8. Have any learning problems?

___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___

Be specific.

Comments:

Has your child had any of the following examinations? If so, please give the approximate date and the examining person's name and place of business name:

**DATE**    **BY WHOM**    **BUSINESS**

Last physical examination:

Neurology

Psychiatry

Psychology

Education

Speech and Hearing

Occupational Therapy

Other special examinations

\*adapted from the Ayers Clinic Development History for Sensory Integration