

Therapy Zone 4 Kidz
17705 Hale Ave. Suite C-4
Morgan Hill, Ca. 95037, (408) 334-0400

DEVELOPMENTAL HISTORY AND BACKGROUND

Child's Name: _____ Date: _____
Birthdate: _____

Current areas of concern (mark all that apply)

<input type="checkbox"/> Gross motor development	<input type="checkbox"/> Sports	<input type="checkbox"/> Fine Motor Development
<input type="checkbox"/> Handwriting	<input type="checkbox"/> Pencil Grip	<input type="checkbox"/> Language
<input type="checkbox"/> Social Skills	<input type="checkbox"/> Eating	<input type="checkbox"/> Sleeping
<input type="checkbox"/> Reading	<input type="checkbox"/> Spelling	<input type="checkbox"/> Math
<input type="checkbox"/> Motivation	<input type="checkbox"/> Moodiness	<input type="checkbox"/> Neatness
<input type="checkbox"/> Getting along with peers	<input type="checkbox"/> Self-confidence	<input type="checkbox"/> Attention/Focus
<input type="checkbox"/> Getting along with adults	<input type="checkbox"/> Easily Frustrated	<input type="checkbox"/> Fearful

Self-Care Skills

I = Independent

F = Frustration interferes with completion

D = Dependent

A = Attention interferes with completion

<input type="checkbox"/> Toileting- wipes self	<input type="checkbox"/> Washes/dries hands
<input type="checkbox"/> Manages clothing for toileting	<input type="checkbox"/> Hair washing
<input type="checkbox"/> Undresses	<input type="checkbox"/> Hair brushing
<input type="checkbox"/> Dresses	<input type="checkbox"/> Brushes teeth
<input type="checkbox"/> Shower	<input type="checkbox"/> Uses fork/spoon
<input type="checkbox"/> Buttons	<input type="checkbox"/> Cuts with Knife/fork
<input type="checkbox"/> Zippers	<input type="checkbox"/> Finger foods
<input type="checkbox"/> Ties shoes	<input type="checkbox"/> Uses open cup
<input type="checkbox"/> Velcro	<input type="checkbox"/> Socks on/off
<input type="checkbox"/> Uses a straw	<input type="checkbox"/> Bath

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:

	<u>DATE</u>	<u>BY WHOM</u>	<u>BUSINESS</u>
Last physical examination:			
<u>Neurology</u>	_____	_____	_____
<u>Psychiatry</u>	_____	_____	_____
<u>Psychology</u>	_____	_____	_____
<u>Education</u>	_____	_____	_____
<u>Speech and Hearing</u>	_____	_____	_____
<u>Occupational Therapy</u>	_____	_____	_____
<u>Other special examinations</u>	_____	_____	_____

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.

<u>BEFORE BIRTH:</u>	YES	NO	REMARKS
1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operation or any other difficulties?			

	YES	NO	REMARKS
2. Were any drugs or medications taken during pregnancy? Specify.			
<u>DELIVERY:</u>			
1. Was the pregnancy full term?			
2. Was the pregnancy premature?			
3. Was it an unusual delivery? (i.e., Breech, Caesarean,)			
4. Was the labor normal?			
5. Was the labor abnormal? (Prolonged, short, specify)			
6. Were forceps used?			
7. Was medication given during delivery? Specify.			
<u>BIRTH:</u>			
1. Was your child considered to be a low birth weight? Specify.			
2. Were there complications such as:			
a. Cyanosis			
b. Jaundice			
c. Congenital defects			
d. Limpness			
3. Was there a need for:			
a. Oxygen			
b. Transfusion			
c. 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?			
<u>MEDICAL HISTORY:</u>	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
1. Has your child had any of the following:			
a. Meningitis			
b. Measles			
c. Chicken pox			
d. High fevers			
e. Mumps			
f. Whooping cough			
g. Scarlet fever			
h. Convulsions			
i. Diabetes			
j. Lung or bronchial difficulties			
k. Heart trouble			
l. Seizures (indicate when, how often)			
m. Allergies			
n. Excessive vomiting			
o. Tuberculosis			

	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
p. Polio			
q. Physical Injuries (if yes, please describe)			
1. Does your child have a vision problem?			
2. Has your child had an eye evaluation? Date of Exam			
3. Does your child have a hearing problem?			
4. Has your child had a hearing evaluation? Date of Exam			
5. Is your child currently on medication? If yes, give a list and state reasons			

<u>DEVELOPMENTAL HISTORY:</u>	<u>AGE</u>		
1. At what age did your child: (please specify ages as near as possible)			
a. Roll over both ways?			
b. Sit alone?			
c. Walk?			
d. Speak his first word (what was it)?			
e. Speak his first sentence (what was it)?			
f. Drink from a cup independently?			
g. Use a spoon independently?			
h. Feed himself independently?			
	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
2. Describe your child as an infant			
a. Cries often, fussy, irritable			
b. Is good, non-demanding			
c. Is alert			
d. Is quiet			
e. Is passive			
f. Is active			
g. Likes being held			
h. Resists being held			
i. Is floppy when held			
j. Is tense when held			
k. Has good sleep patterns			
l. Has irregular sleep patterns			
3. Describe your child at present			
a. Is mostly quiet			
b. Is overly active			
c. Tires easily			
d. Talks constantly			
e. Too impulsive			

	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
f. Is restless			
g. Is stubborn			
h. Is resistant to changes			
i. Over reacts			
j. Fights frequently			
k. Is usually happy			
l. Exhibits frequent temper tantrums			
m. Is clumsy			
n. Has difficulty separating from primary caretaker			
o. Has nervous habits or tics			
p. Falls often			
q. Is frustrated easily			
r. Has unusual fears			
s. Rocks self frequently			
t. Has difficulty learning new tasks (i.e., using a toy)			
u. Has poor attention span			
<u>Language:</u>			
1. Does your child seem to understand what is said to him?			
2. Did your child start to talk and then stopped?			
<u>SENSORY HISTORY:</u>	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
<u>Auditory:</u>			
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. Get distracted by ambient noise (lights, air condit.)?			
<u>Gustatory-Olfactory-Elimination:</u>			
Does your child			
1. Act as though all food tastes the same?			
2. Chew on non-food objects?			
3. Is your child a “picky eater”?			
4. Have unusual cravings for certain foods:			
5. Dislike food of certain texture?			
6. Explore by smelling?			

	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
7. Discriminate odors?			
8. React negatively to smell?			
9. Ignore unpleasant odors?			
10. Have trouble with constipation?			
<u>Visual:</u>			
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. Squint often?			
6. Have difficulty with focusing on things far away?			
7. Have difficulty with visually focusing on things close?			
8. Have trouble with reading?			
<u>Tactile:</u>			
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. Dislike wearing shoes and/or socks			
5. Object to being touched?			
6. Dislike being touched unexpectedly?			
7. Dislike being cuddled?			
8. Prefer to touch rather than be touched?			
9. Avoid using hands for extended periods?			
10. Bang his head on purpose now or in the past?			
11. Pinch, bite or otherwise hurt himself?			
12. Examine objects by putting them into his mouth?			
13. Tend to feel more or less pain than others? (circle one)			
<u>Motor:</u>			
Does Your child			
1. Appear clumsy/avoid balance activities?			
2. Seems to have excessive energy?			
3. Bump into people/objects?			
4. Break toys easily/crush things?			
5. Seeks running/crashing/jumping?			
6. Appear to have “aggressive” behavior?			
7. Have trouble following/understanding directions?			
8. Spin/twirl excessively?			

	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
9. Have car sickness?			
10. Have "soft" muscles/low tone?			
11. Tantrums easily/overly emotional?			
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?			
Does your child exhibit difficulty with			
1. Cutting or pasting?			
2. Playing with small manipulative toys?			
3. Learning to hold a pencil or crayon with a 3 finger grasp?			
4. Learning how to use playground equipment?			
Comments:			
<u>Social Adjustment:</u>			
Does your child			
1. Calm down independently?			
2. Find it hard to make friends among his peers?			
3. Prefer the company of adults, or older children?			
4. Prefer to play with younger children?			
5. Frequently express feeling of failure or frustration?			
6. Play with toys appropriate for his age?			
Comments:			
<u>School Performance:</u>			
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:			

*adapted from the Ayers Clinic Development History for Sensory Integration