

**DEVELOPMENTAL HISTORY FOR OCCUPATIONAL THERAPY EVALUATION OF
SENSORY INTEGRATION AND PRAXIS**

CHILD'S NAME: _____ **DATE:** _____

BIRTHDATE: _____

Reviewed by: _____ (parent) _____ (therapist)

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

<u>BEFORE BIRTH:</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operations, or any other difficulties?			
2. Were there any drugs of medication taken during pregnancy? Specify.			
<u>DELIVERY:</u>			
1. Was the pregnancy full term?			
2. Was the pregnancy premature? (Give months and weight)			
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? (Give details).			
7. Was medication given during delivery? Specify.			
<u>BIRTH:</u>			
1. Was you child considered to be a low birth weight? Specify.			
2. Were there complications such as:			
a. Low birth weight? Specify.			
b. Jaundice			
c. Congenital defects			
d. Limpness			
3. What were your child's APGAR scores?			
4. Was there a need for:			
a. Oxygen			
b. Transfusions			
c. Tube feedings			
5. Were there any feeding difficulties? Specify.			
6. Was the child bottle fed?			

7. Was the child breast-fed?			
8. Did the child have problems sucking?			
9. Was the length of infant's stay in the hospital unusually long? Specify.			
Comments:			
<u>MEDICAL HISTORY:</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
1. Has your child had any of the following? Please give dates and indicate whether the child had the illness or was immunized.			
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			
p. Polio			
q. Physical injuries. If yes, describe.			
r. Ear infections. If yes, specify frequency, how identified, and how treated.			
2. Has your child had any hospitalizations? When? For what? For how long?			
3. Did you notice any change in his/her speech development following any of the illnesses? Any change in hearing? Specify results.			
4. Does your child have a vision problem?			
5. Has your child had an eye			

evaluation? By whom: _____ Date: _____			
6. Does you child have a hearing problem?			
7. Has your child had a hearing evaluation? By whom: _____ Date: _____			
8.Is you child currently on medication? If yes, give a list and state reason.			
Comments:			
<u>DEVELOPMENTAL HISTORY:</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS</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/her first word (What was the word?)			
e. Speak his/her first sentence (What was it)			
f. Use 2 words together (example)			
g. Use 3 words together (example)			
h. Drink from a cup independently			
i. Use a spoon independently			
j. Feed him/herself independently			
k. Put on a shirt independently			
l. button independently			
m. Dress him/herself independently			
2. Describe your child as an infant...			
a. Cried a lot, fussy, irritable			
b. was good, non-demanding			

c. Was alert			
d. Was quiet			
e. Was passive			
f. Was active			
g. Liked being held			
h. Resisted being held			
i. Was floppy when held			
j. Was tense when held			
k. Had good sleep patterns			
l. Had irregular sleep patterns			
2. Describe your child at present...			
a. Is mostly quiet			
b. Is overly active			
c. Tires easily			
d. Talks constantly			
e. Too impulsive			
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. Wets bed			
r. Has poor attention span			
s. Is frustrated easily			
t. Has unusual fears			
u. Rocks self frequently.			
v. Has difficulty learning new tasks (i.e. writing, throwing a ball, riding a bike, etc.)			
Comments:			
<u>LANGUAGE:</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
1. Did your child start to talk and then stopped?			
2. Does your child sometimes speak phrases heard in the past yet repeats it out of context or not in relation to appropriate situations?			
3. What kinds of things can your child do when asked? Please provide example, including			

phrasing used.			
4. Can you tell him/her to do 2 things at one time? (With the desired result)?			
5. Does he/she ask questions? Please specify which question types.			
7. Does your child have words for objects and actions?			
8. Does your child seem to acquire and use new words rapidly or slowly? Specify			
Comments:			
<u>MOTOR:</u> Can your child...	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
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 a swing			
7. Kick a ball			
Does your child exhibit difficulty with...			
1. Cutting or pasting			
2. Small manipulative toys			
3. Learning to hold a pencil or crayon in a 3 point position			
4. Learning how to use playground equipment			
Comments:			
<u>SOCIAL ADJUSTMENT:</u> Does your child...	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
1. Find it hard to make friends among peers			
2. Prefer the company of adults, or older children			
3. Prefer to play with younger children			
4. Frequently express feelings of failure and frustration			
5. play with toys appropriate for			

his age			
6. Does your child play alongside or together with other children (specify) How and what do they play?			
7. Is he/she more vocal/verbal when playing with/near other children?			
Comments:			
<u>SCHOOL PERFORMANCE:</u> Does your child...	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
1. Need to prop his/her head in his/her hand while reading or writing at the desk			
2. Is there confusion over which hand is dominant			
3. Mix up which hand or foot is right or left	<u>YES</u>	<u>NO</u>	<u>SOMETIMES</u>
4. Make reversals of letters or numbers when writing			
5. Read words in reverse			
6. Find P.E. or sports to be a difficult or frustrating experience			
7. Have any learning problems? Be specific			
<u>ELIMINATION:</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
1. Does your child have trouble with constipation?			
2. Does your child have trouble learning urinary control?			
3. Does your child have trouble learning bowel control?			
Comment:			

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

	<u>Date</u>	<u>By whom</u>	<u>Address</u>
Last physical examination			
Neurology			
Psychiatry			

Psychology

Education

Speech and Hearing

Other special examinations

Any additional information that would help to better understand your child:

Reviewed By: _____

Date: _____

Recommend Social/psychological services: Yes ___ No ___