Developmental/Sensory History

Early Childhood

Date: _____

Parents: This history may appear to be quite long. However, a number of the questions require checking off responses which can be done quickly. This information is very useful in gaining a clear understanding of your child's strengths and weaknesses. We appreciate your time.

General information

Child's Name: _____
(first) (last) (nickname)

Birth Date: _____ Phone #: _____

Address: _____

City/State/Zip: _____

Parent/Guardian's Name: _____ Occupation: _____

Employer: _____ Phone #: _____

Parent/Guardian's Name: _____ Occupation: _____

Employer: _____ Phone #: _____

Names and ages of siblings: _____

_____

Emergency Contact Person (name, relationship, phone #): _____

_____

Referred by (name, relationship, phone #): _____

_____

Child's Physician (name, address, phone #): _____

Does your child attend: □ Nursery School/Preschool: _____

□ Early Intervention Program: _____

Medical Information

Has your child received previous evaluation and/or treatment by an occupational therapist? □ Yes □ No

If yes, when and where: _____

Medical diagnosis (if any): _____

Has your child had a vision test? □ Yes □ No If yes, when? _____

Has your child had a hearing test? □ Yes □ No If yes, when? _____

If yes, what were the results of hearing and vision tests? _____

_____

_____

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Early Childhood

Medical information (continued)

Has your child had any of the following? If yes, describe and give appropriate dates.

Childhood diseases or major illnesses:_____

Congenital abnormalities:_____

Surgeries:_____

Serious injury:_____

Casts or braces:_____

Ear infections:_____

Tubes in ears:_____

Allergies:_____

Seizures:_____

Other:_____

_____

List any medications your child is currently receiving and frequency of dosages:_____

_____

Has your child received medications in the past for any of the above-mentioned conditions? □ Yes □ No

If yes, what and when:_____

Are there any medical precautions the therapist should be aware of when working with your child? □ Yes □ No

If yes, what are they:_____

Does your child have any assistive devices (such as glasses, casts, or wheelchair)? □ Yes □ No

If yes, what are they:_____

Has your child received other evaluations or treatment (psychological, speech and language, neurology)?

□ Yes □ No If so, what type and by whom?

Type	Eval. Date	Professional's Name	Dates of Therapy

What do you hope to get from this evaluation and/or treatment?

_____

_____

_____

_____

_____

_____

Developmental/Sensory History

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Mother's Health during Pregnancy

Did the mother:

1. Have any infections/illnesses during pregnancy: □ Yes □ No
   Describe:_____
2. Have any shocks or unusual stresses during pregnancy: □ Yes □ No
   Describe:_____
3. Receive any medication during pregnancy: □ Yes □ No
   Describe:_____
4. Have any complications during delivery/labor: □ Yes □ No
   Describe:_____

Child's Birth

Was or did child:

1. Full term?_____ □ Yes □ No Weight at birth: _____
2. Premature?_____ □ Yes □ No Number of weeks: _____
3. Small for gestational age (SGA)? □ Yes □ No
4. Breech (feet first)? □ Yes □ No
5. Require forceps for delivery? □ Yes □ No
6. Require suction for delivery? □ Yes □ No
7. Have any birth injuries? □ Yes □ No

Describe:

8. If known, APGAR score at one minute: _____ At five minutes: _____
9. Require intensive-care hospitalization? □ Yes □ No How long? _____
10. Jaundiced? □ Yes □ No Length of treatment? _____

Infancy and Early Childhood

Does or did your child:

1. Have feeding problems? □ Yes □ No If yes, describe: _____
   _____
2. Have sleeping problems? □ Yes □ No If yes, describe: _____
   _____
3. Have colic? □ Yes □ No For how long? _____
4. Prefer certain positions as a child? □ Yes □ No If yes, describe: _____
   _____

Developmental/Sensory History

Early Childhood

Infancy and Early Childhood (continued)

5. Dislike lying on stomach? □ Yes □ No
6. Dislike lying on back? □ Yes □ No
7. Enjoy bouncing? □ Yes □ No
8. Become calmed by car rides or infant swings? □ Yes □ No
9. Become nauseated by car rides or infant swings? □ Yes □ No
10. Tend to always be generally compliant? □ Yes □ No
11. Go through "terrible twos"? □ Yes □ No

If no, describe child's toddler stage:_____

Developmental Milestones

(Give approximate ages if remembered, or comment on anything unusual)

Roll over:_____ Walk:_____ Say words:_____ Sit alone:_____ Chew solid food:_____ Say sentences:_____

Crawl:_____ Drink from a cup:_____

Was crawling phase brief? □ Yes □ No Absent? □ Yes □ No

Did child use a walker (rolling plastic seat)? □ Yes □ No How often: _____

Experience hesitancy or delays in learning to go down stairs? □ Yes □ No

Did child climb out of crib independently? □ Yes □ No If yes, at what age: _____

Sensory History

Please check the appropriate area, comment as desired, and cross out any parts of questions that do not apply.

VISUAL-SPATIAL PROCESSING Does child:	Often	Some-times	Rarely/ Never	Comments
1. Become easily distracted by visual stimulation?				
2. Dislike having eyes covered?				
3. Like playing in the dark?				
4. Blink at bright lights or seem irritated by them?				
5. Turn eyes away from adult eye contact early in infancy?				
6. Have trouble following objects with the eye?				
7. Avoid or have difficulty with eye contact?				

Developmental/Sensory History

Early Childhood

VISUAL-SPACIAL PROCESSING (continued)	Often	Some-times	Rarely /Never	Comments
8. Play in enclosed spaces such as play houses?				
9. Dislike having head covered with a blanket?				

10. Have a favorite color? □ Yes □ No What color? _____
Is the child strongly attached to this color? □ Yes □ No

AUDITORY AND LANGUAGE PROCESSING Does/is child:	Often	Some-times	Rarely /Never	Comments
1. Like to sing or dance to music?				
2. Have difficulty maintaining or copying rhythms?				
3. At times seem not to understand what is said?				
4. Seem overly sensitive to sound?				
5. Become distracted by lots of noise?				
6. Become distracted by background noises such as refrigerators, florescent lights, fans?				
7. Seem to have trouble remembering what was said?				
8. Have speech or articulation difficulties?				
9. Have trouble expressing what child wants?				
10. Unable to follow two or three directions given at once?				

Developmental/Sensory History

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MOVEMENT Does/is child:	Often	Some-times	Rarely /Never	Comments
1. Enjoy swings?				
2. Seem to have good balance?				
3. Enjoy merry-go-rounds or fast carnival rides?				
4. Like being tipped upside down or lifted overhead?				
5. Hesitate or avoid climbing on equipment such as jungle gyms?				
6. Hesitate or have difficulty going down stairs?				
7. Seem fearful of catching balls?				
8. Fearful when laid back for diaper changes?				
9. Walk on toes?				
11. Jump a lot on beds or other surfaces?				
10. Bang head on purpose?				
12. Rock in bed?				
13. Like to spin self around?				
14. Become carsick easily?				
15. Afraid of sitting on a tall chair with feet off the floor?				
16. Dislike lying on surface higher than a bed (such as doctor's exam table, changing table)?				
17. Dislike rocking chairs (by self or in an adult's lap)?				
18. Become upset if head is tilted backwards as in hair washing?				

Developmental/Sensory History

Early Childhood

MOVEMENT (continued)	Often	Some-times	Rarely /Never	Comments
Enjoy walking on uneven surfaces (for example, pillow on floor)?				
19. Fearful of elevators?				
20. Enjoy spinning on swings, sit and spins, etc?				
21. Fall asleep easily in a car?				

TASTE AND SMELL Does child:	Often	Some-times	Rarely /Never	Comments
1. Tend to explore with smell; deliberately smell objects?				
2. React defensively or seem overly sensitive to some odors?				
3. React defensively to the taste and texture of many foods?				
4. Act as though all foods taste the same?				
5. Have more difficulty eating textured foods compared to smooth foods?				
6. Prefer crunchy-textured foods?				
7. Have difficulty eating foods with a few lumps (such as soup)?				
8. Lick suck or chew on nonfood items (past 18 months)? What items? (write in “Comments”)				

What food does your child prefer? _____

Developmental/Sensory History

Early Childhood

TOUCH (TACTILE PROCESSING) Does child:	Often	Some-times	Rarely /Never	Comments
1. Seem excessively ticklish?				
2. Become irritated by labels or tags sewn in clothing?				
3. Prefer to touch rather than be touched?				
4. Strongly dislike haircutting or shampooing?				
5. Dislike fingernail or toenail cutting?				
6. Tend to examine objects by touching thoroughly with hands (past two years)?				
7. Have difficulty petting animals, may use too much force?				
8. Complain if socks aren't on correctly?				
9. Seem to crave being held and cuddled?				
10. Dislike being touched unexpectedly?				
11. Tend to prefer long sleeves and pants regardless of weather?				
12. Dislike cloth of certain textures?				
13. Avoid getting hands into paste, finger paints, or messy things?				
14. Often seem overly active?				
15. Tend to bump or push others?				
16. Tend to be more sensitive to pain than other children?				
17. Become especially bothered by small cuts?				
18. Tend to not feel pain as much as others?				

Developmental/Sensory History

Early Childhood

TOUCH (TACTILE PROCESSING) (continued)	Often	Some-times	Rarely /Never	Comments
19. Seem oblivious to bruises and heavy falls?				
20. Tend to remove shoes whenever possible?				
21. Complain that others often hit or push the child?				
22. Pinch, bite, or otherwise hurt self?				
23. Tend to masturbate frequently?				
24. Over- or under-dress for the temperature?				
25. Overheat easily?				
26. Become upset when coming out of a bath?				
27. Become extremely irritated when splashed with water?				
28. Dislike walking barefoot on grass or sand?				
29. Seem overly sensitive to food or water temperature?				
30. Dislike hand and face washing?				
31. Dislike having hand held by adult or other children?				
32. Dislike hugs and cuddling?				
33. Dislike tooth brushing?				
34. Dislike wearing adhesive bandages or stickers?				

Developmental/Sensory History

Early Childhood

SOCIAL Does child:	Often	Some-times	Rarely /Never	Comments
1. Make friends easily				
2. Tend to prefer to play alone?				
3. Have a strong desire for sameness and routine?				
4. Tend to crave attention?				
5. Seem sensitive to criticism?				
6. Lack self-confidence?				
7. Have strong outbursts of anger, tantrums?				
8. Have trouble getting along with other children?				
9. Have difficulty calming down after active play?				
10. Tend to be quiet and withdrawn?				
11. Tend to lack carefulness, be impulsive?				
12. Tend to be relaxed and patient?				
13. Tend to be intense, easily frustrated?				
14. Tend to be in perpetual motion?				
15. Tend to have difficulty separating from parents?				
16. Tend to be very set in routines?				
17. Prefer the company of adults to children?				
18. Hit or bite other children?				
19. Seem discouraged or depressed?				

Developmental/Sensory History

Early Childhood

MOTOR SKILLS Does child:	Often	Some-times	Rarely /Never	Comments
1. Bump into things frequently?				
2. Have difficulty with motor tasks that have several steps?				
3. Approach new motor activities in an overly cautious manner?				
4. Avoid drawing activities?				
5. Have difficulty walking around chairs or toys without bumping into them?				
6. Seem shaky when doing fine motor tasks?				
7. Seem weaker than others of same age?				
8. Frequently grasp objects very tightly?				
9. Tend to break many objects?				
10. Drop things easily?				
11. Tire easily with physical activity?				
12. Seem to deliberately fall or tumble?				
13. Tend to eat in a sloppy manner?				
14. Find small manipulative activities difficult?				
15. Prefer playground activities to table activities?				
16. Prefer table activities to playground activities?				
17. Perform movements in a slow and plodding fashion?				
18. Take a long time to do most motor tasks?				
MOTOR SKILLS (continued) Does child:	Often	Some-times	Rarely /Never	Comments

Developmental/Sensory History

Early Childhood

19. Appear reluctant to participate in gross motor activities?				
20. Tend to move in and out of chair while eating or doing work?				
21. Feel heavier when lifted than anticipated?				
22. Have flat feet?				
23. Slump while sitting?				
24. Have difficulty handling eating utensils?				
25. Frequently spill liquids?				
26. Drool?				
27. Keep mouth open most of the time?				
28. Have trouble chewing?				
29. Have difficulty giving a kiss?				
30. Have difficulty getting in and out of a car seat?				
31. Have difficulty getting in and out of a high chair?				
32. Seem to be a “dare devil,” unaware of necessary safety concerns?				

Bowel and Bladder

1. Is your child toilet-trained? □ Yes □ No
2. At what age did your child:
   - Indicate discomfort of soiled pants? _____
   - Anticipate need to eliminate? _____
   - Indicate need to use toilet? _____
   - Begin toilet training? _____

Bowel and Bladder (continued)

3. Does or did your child:

Developmental/Sensory History

Early Childhood

- Continue to have accidents during the day? □ Yes □ No
- If no, trained at what age? _____
- Continue to have accidents during the night? □ Yes □ No
  If no, trained at what age? _____
- Seem fearful of sitting on toilet? □ Yes □ No

Sleep Patterns

Does child:

1. Have regular sleep patterns? □ Yes □ No If no, describe: _____
   _____
2. Wake frequently during the night? □ Yes □ No If no, describe: _____
   _____
3. Tend to be an early riser, up and on the go? □ Yes □ No
4. Have a difficult time falling asleep? □ Yes □ No

Play Skills

1. What are your child's favorite play things? _____
   _____
2. What does your child do with these toys? _____
   _____Who
   does your child prefer to play with? _____
   _____
3. What activities do your child least enjoy? _____
   _____
4. Are there any things which your child tends to fear or avoid? □ Yes □ No
   If yes, describe: _____
5. How long does your child play with one toy? _____
6. Does your child tend to play while in one position more than the others? □ Yes □ No
   If yes, what position? _____
   Does your child tend to play with things by lining them up or piling them up? (if over two years of age)
   □ Yes □ No If yes, describe
7. What extra-curricular activities are your child involved in (such as gymnastics, swimming lessons, etc.)?
   _____
   _____

DEVELOPMENTAL SKILLS Can your child:	Often	Some- times	Rarely /Never	Comments

Developmental/Sensory History

Early Childhood

1. Sit independently?				
2. Walk independently?				
3. Walk up and down stairs?				
4. Climb on playground equipment?				
5. Throw a ball?				
6. Catch a ball?				
7. Propel a riding toy with feet?				
8. Ride a tricycle or similar toy?				
9. Pick up small objects with fingers?				
10. Stack rings on a ring stand?				
11. Turn pages of a book?				
12. Stack blocks?				
13. Complete single piece puzzles?				
14. Complete interlocking puzzles?				
15. Color with crayons?				
16. Draw lines and circles?				
17. String beads?				
18. Finger-feed self?				
19. Drink from a cup?				
20. Feed self with a spoon?				
21. Hold up arms and legs for dressing?				

DEVELOPMENTAL SKILLS (continued)	Often	Some-times	Rarely /Never	Comments

Developmental/Sensory History

Early Childhood

22. Unzip a jacket?				
23. Undress self?				
24. Put on/take off shoes?				
25. Unbutton large buttons?				
26. Blow soap bubbles?				
27. Blow whistles?				
28. Drink from a straw?				
29. Kick a ball?				

What particular skills would your child to achieve in the next six months? _____

_____

_____

_____

_____

_____

_____

_____

_____

How, if in any way, would you like to interact differently with your child? _____

_____

_____

_____

_____

_____

_____

_____

_____