Trusted Therapy, Inc
Developmental History Form

Date: _____

Child's Full Name: _____ Sex: _____

Age: _____ Date of Birth: _____

Grade: _____ School: _____

Primary Language: _____ Language spoken at Home: _____

Home Address: _____

Home Phone: _____

Parent Name: _____ Parent Name: _____

Email: _____ Email: _____

Cell Phone: _____ Cell Phone: _____

Parent's Employer: _____ Parent's Employer: _____

Parent's DOB: _____ Parent's DOB: _____

Briefly describe the problems/concerns:

1. _____
2. _____
3. _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

Primary phone number: _____ Alternative phone number: _____

Pediatrician: _____ Address: _____

Pediatrician's phone number: _____

DEVELOPMENTAL HISTORY

Was this child adopted? _____

If yes, where was your child born? _____ How old was your child when placed in your care? _____

PRENATAL DEVELOPMENT

Was this child was conceived through in vitro fertilization? ____

Did mother receive medicines to increase fertility? ____

Number of ultrasounds during pregnancy: ____

Please describe any abnormal findings: _____

Was the child a multiple birth? ____
Was the child born first, second, etc? ____

Was the child planned? _____

COMPLICATIONS WITH PREGNANCY

(Please check off any of the following complications experienced by the mother while pregnant with this child)

Anemia ____ High Blood Pressure ____ Toxemia ____ Bleeding ____ German Measles ____ Injury ____

RH incompatibility ____ Chronic Illness ____ Surgery ____ Threatened Miscarriage ____ Other _____

Please describe any of the complications endorsed above:

_____

_____

Please list and describe other complications/illnesses mother experienced during pregnancy:

_____

_____

Please list any medications prescribed to mother during pregnancy:

_____

_____

MOTHER'S HEALTH HABITS WHILE PREGNANT

(Please answer the following questions)

Did the mother smoke cigarettes while pregnant? If yes, how often? _____

Did the mother drink alcohol while pregnant? If yes, how often?_____

Did the mother use any type of drugs while pregnant? If yes, what type and how often? _____

BIRTH HISTORY

(Please answer the following questions)

How long was labor (i.e., how many hours from first contractions to birth)? _____

Was your baby born premature? _____ If yes, how many days? _____

After birth did your child stay in: Well-baby Nursery _____ Neonatal Intensive Care Unit (NICU) _____

DELIVERY/POST DELIVERY

(Please check off any of the following items that pertain to the delivery and post delivery of this child)

☐ Natural childbirth ☐ Induced ☐ Breeched ☐ Cesarean ☐ Use of Anesthesia ☐ Use of Forceps

☐ Cord around neck ☐ Abnormal color ☐ Baby did not cry right away ☐ Difficulty breathing

☐ Received oxygen ☐ Received transfusions ☐ Received phototherapy ☐ Needed a respirator

Please describe any additional complications:

_____

_____

Please describe any medical problems your child had while in the nursery:

_____

_____

Did mother and infant leave the hospital together? _____
If not, please provide the reason: _____

EARLY INFANT DEVELOPMENT

(Please check off any of the following items that describe the child in the infancy)

Poor weight gain ____ Active baby____ Limp ____ Stiff ____ Tremors ____ Convulsions ____

Difficulty sucking ____ Difficulty chewing ____

Was the baby colicky? ____ If yes, how long? _____

Was the baby breast fed? _____ If yes, how long? _____

Was the baby bottle fed? _____ If yes, for how long? _____

Was/Is your child on special diet? _____ Please describe diet: _____

Please describe any other feeding issues? (sensitivities, textures, reflux, resistance, difficulty swallowing, drooling, etc.)

DEVELOPMENTAL MILESTONES

(Please note the age the following were achieved. If unsure of the age, check whether it was achieved early, late or within normal limits)

	Age	Early	Normal	Late		Age	Early	Normal	Late
Rolled over	_____	☐	☐	☐	Tied shoes	_____	☐	☐	☐
Sat without support	_____	☐	☐	☐	Pedaled tricycle	_____	☐	☐	☐
Grasped pencil/crayon	_____	☐	☐	☐	Rode bike	_____	☐	☐	☐
Crawled	_____	☐	☐	☐	Grasped pencil/crayon	_____	☐	☐	☐
Stood up	_____	☐	☐	☐	Swam	_____	☐	☐	☐
Walked holding on	_____	☐	☐	☐	Babbled	_____	☐	☐	☐
Walked without holding on	_____	☐	☐	☐	Spoke first words	_____	☐	☐	☐
Fed self	_____	☐	☐	☐	Put two words together	_____	☐	☐	☐
Dressed self	_____	☐	☐	☐	Spoke in short sentences	_____	☐	☐	☐

LANGUAGE DEVELOPMENT

At what age was your child easily understood by others? _____

(Please check off the following items that relate to your child's language)

- ☐ Often asks others to repeat what they have said
- ☐ Unable to understand what you are saying
- ☐ Unable to follow one step directions
- ☐ Unable to follow multi-step directions
- ☐ Unable to remember short messages
- ☐ Unable to respond correctly to yes/no questions
- ☐ Unable to respond correctly to who/what/where/when/why questions
- ☐ Has a hard time expressing his/her ideas
- ☐ Has a hard time asking for help/or making his/her wants and needs known to others
- ☐ Child does not enjoy listening to stories
- ☐ Repeats sounds, words, or phrases over and over
- ☐ Names things around the house and/or people
- ☐ Mispronounces words or leaves off sounds in words
- ☐ Leaves off small words (the, is, to) when speaking in sentences
- ☐ Leaves off endings (plurals, -ed) when speaking in sentences
- ☐ Child avoids being read to
- ☐ Gets frustrated when explaining things orally
- ☐ Trouble finding words s/he wants to use
- ☐ Talks around an issue without coming to the point

Is your child's speech:

- ☐ Usually loud
- ☐ Usually soft
- ☐ Hoarse, breathy, or strained-sounding
- ☐ Dysfluent
- ☐ Filled with "um" and "you know"
- ☐ Unable to be understood by familiar others
- ☐ Unable to be understood by unfamiliar others

Your child currently communicates using:

- ☐ Body language
- ☐ Sounds (vowels and vocalizations)
- ☐ Other:
- ☐ Single words
- ☐ 2 to 4 word sentences

Has your child ever had speech therapy? If yes, please specify where and when. If possible, please give any information related to goals at that time or currently.

SENSORIMOTOR DEVELOPMENT

(Please check off the following items that relate to your child's sensory and motor skills)

TACTILE (TOUCH):

☐ Has trouble managing personal/physical space
☐ Over sensitive to clothing/textures/foods
☐ Under sensitive to clothing/textures/foods

VISUAL

☐ Has passed most recent vision screening
☐ Has trouble tracking objects with eyes
☐ Avoids eye contact with others
☐ Has trouble copying words from the board

AUDITORY (SOUND)

☐ Passed most recent hearing screening
☐ History of PE tubes in his/her ears
☐ History of frequent ear infections
☐ Sensitive to loud sounds (school bells, sirens)
☐ Fails to listen, or pay attention to what is said to him/her
☐ Has difficultly if 2 or 3 steps instructions are given at once
☐ Talks excessively/ not wait his/her turn

TASTE & SMELL

☐ Picky eater
☐ Has trouble eating different textured foods
☐ Sensitive noxious smells/tastes
☐ Insensitive to noxious smells/taste
☐ Prefers spicy, sour bitter food flavors

VESTIBULAR (MOVEMENT)

☐ Loses balance easily
☐ Likes rough housing, jumping, crashing games
☐ Get carsick easily
☐ Prefers to be sedentary (on computer/ TV) rather than play outside?

MUSCLE TONE

☐ Slouches when sitting on floor/chair
☐ Gets tired easily playing or writing
☐ Seems generally weak compared to other kids

COORDINATION

☐ Has difficulty with sequential tasks; dressing, buttoning
☐ Has difficulty playing on playground equipment
☐ Has difficulty holding a pencil or crayon in a 3-point position
☐ Does not enjoy sports
☐ Poor ball skills for P.E. type activities
☐ Seems clumsy, awkward
☐ Bumps into furniture, people often
☐ Left Handed
☐ Right Handed
☐ Mixed hand preference/Ambidextrous
☐ Poor handwriting
☐ Has trouble using both hands together easily (opening milk carton, water bottle etc.)
☐ Cannot ride a bike
☐ Cannot tie shoelaces

SLEEP *(Please check off the following items that relate to your child's sleep)*

What time does your child go to sleep? _____ PM
What time does your child wake up? _____ AM

☐ Difficulty staying asleep
☐ Difficulty falling asleep
☐ Frequent wakening
☐ Sleep walking
☐ Nightmares
☐ Recurrent nightmares

Describe any past or present concerns/difficulties regarding your child's sleep patterns: _____

TOILETING *(Please note when the following milestones were achieved)*

	Age	Early	Normal	Late
Trained for urine	_____	☐	☐	☐
Trained for bowels	_____	☐	☐	☐

Please check off any of the following difficulties relate to your child's toilet training. Please describe any of the difficulties endorsed above, including frequency in the space provided.

☐ Bed wetting after training
☐ Night-time soiling after training
☐ Urine accidents during the day
☐ Soiling during the day

CURRENT BEHAVIOR *(Please check off the following items that relate to your child's current behavior)*

- ☐ Shy
- ☐ Immature
- ☐ Well behaved
- ☐ Stubborn
- ☐ Impulsive
- ☐ Temper tantrums
- ☐ Cries excessively
- ☐ Tells lies
- ☐ Thumb sucking
- ☐ Head banging
- ☐ Nail biting
- ☐ More active than other children
- ☐ Clumsy using hands
- ☐ Poor handwriting
- ☐ Clumsy walking
- ☐ Blank spells
- ☐ Fainting spells
- ☐ Tics and twitching
- ☐ Always in motion
- ☐ Excessively fidgety
- ☐ Difficulty paying attention
- ☐ Difficulty staying at one task for a long time
- ☐ Gets distracted while watching TV
- ☐ Difficulty with transitions
- ☐ Difficulty with finishing a task
- ☐ Disorganized
- ☐ Shows poor judgment in dangerous or questionable situations
- ☐ Poor awareness of time
- ☐ Gets lost easily
- ☐ Frequent Accidents
- ☐ Destructive/aggressive
- ☐ Difficulty listening
- ☐ Gets easily frustrated
- ☐ Has poor self-esteem
- ☐ Fears making mistakes
- ☐ Eats paint, paper, etc.
- ☐ Moods change quickly
- ☐ Difficulty understanding jokes
- ☐ Self-abusive behavior
- ☐ Withdrawn
- ☐ Stubborn
- ☐ Poor eye contact
- ☐ Plays alone for a reasonable length of time
- ☐ Cooperative
- ☐ Attentive
- ☐ Willing to try new activities

Were any of the above behaviors significant issues which have now gone away? If so, please explain below:

MEDICAL HISTORY

(Please check off whether your child experienced any of the following conditions. Please describe any of the conditions endorsed above, including age of onset/occurrence in the space provided.)

- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Braces or other orthodontic appliances
- ☐ Ear infections
- ☐ Ear tubes (If yes, when) _____
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Diabetes
- ☐ Asthma
- ☐ Allergies
- ☐ Seizures
- ☐ Head injury which required medical attention
- ☐ Loss of consciousness
- ☐ Heart defects

Please describe any hospitalizations or injuries your child may have had

Please report any medical diagnoses or conditions

Please check if your child complains of any of the following conditions, and note how frequent the complaints occur in the space provided.

☐ Headache _____
☐ Nausea _____
☐ Vomiting _____
☐ Weakness _____
☐ Dizziness _____
☐ Stomachache _____
☐ Aches or pains _____
☐ Trouble with hearing _____
☐ Chronic constipation_____
☐ Trouble with vision _____

Please list all previous medications that were taken for more than one month:

Name	Dose	Reason Given

Current Medications

Vision

Visual defects ____
Glasses: Yes or No If yes, for what reason: _____

Date of last vision screen: _____

Results: _____

Hearing

Hearing Problems: Please circle Yes or No If yes, for what reason: _____

Date of last hearing screen: _____

Results: _____

Please explain if you consulted with any other medical specialists for your child?

Does your child have a diagnosis from a pediatrician, psychologist, psychiatrist, or other professional? If yes, please describe.

Has child received any psychological or psychiatric treatment?

If yes, please describe:

Were improvements noted?

Has the child ever experienced any parental separations, divorce, or death?

If yes, when? How old was the child at the time?
Please describe the circumstances:
Does the child have trouble separating now?

EDUCATIONAL HISTORY

(Please check off any of the following which relate to your child's educational background)

Child attended nursery school ☐ Child attended Kindergarten ☐

What (if any) problems were reported?

List all prior schools attended (and years of attendance):

Current school: _____

Teacher's name: _____

School Address: _____

School phone number: _____

Current grade placement: _____

Describe any problems at school:

☐ Retentions (Grade): _____

☐ Suspensions: _____

☐ Regular classroom ☐ Special ed/placements: _____

(If your child has an Individualized Education Plan or 504 Plan, please provide copies of these plans)

Age the child was placed in special education:

Please describe what supports/services are provided by your child's school:

Please describe any noted improvements:

Please describe any private support/services your child receives:

☐ School psychological testing was completed

Testing results: (please provide copies of previous testing)

What are your child's strengths and/or best subjects?

Is your child having difficulty with any subjects?

Please check off if any of the following problems were reported by your child's school or teacher:

☐ Reading
☐ Spelling
☐ Math
☐ Writing
☐ Behavior
☐ Social Adjustment
☐ Attention Span
☐ Distractibility
☐ Hyperactivity
☐ Following Directions
☐ Getting along with other children
☐ Getting along with teachers
☐ Does not complete homework readily

Please describe your child's attitude towards school:

Has your child ever missed an extended amount of school?
If so, please explain: _____

Has your child ever had any of the following evaluations performed in school or privately? *(Please provide copies of all prior test reports)*

	Name of Evaluator	Date of Evaluation	Findings
Physical Therapy			
Occupational Therapy			
Speech & Language			
Audiology			
Psychology			
Neurology			
Other:			

Has your child ever received any of the following therapies in school or privately? Explain.

Physical Therapy	
Occupational Therapy	
Speech & Language	
Social Worker	
Psychologist	
Other:	

SOCIAL EMOTIONAL DEVELOPMENT

Describe your child's current social skills and peer relationships. Please note if your child has a history of being bullied/teased or has been aggressive in play with others:

How would you describe your child socially? How do you think your child interacts with peers while at school?

Does your child have difficulty keeping friends?

Does your child have a best friend?

What special interests does your child have?

Please list your child's favorite hobbies, activities, and games, other than sports (e.g. piano, books, dolls, crafts, cars, etc.). Also, please describe how well you feel your child does in these areas:

Which sports does your child most enjoy playing? Describe how well your child does in these sports compared to peers:

Please list any additional organizations, clubs, teams, or groups in which your child participates:
How does your child handle stress?

What are your child's strengths?

In what areas would you like to see your child stronger?

Any other pertinent information that you would like to share?

FAMILY HISTORY

Other Pregnancies:
List in order of birth, including the child to be seen:

Year	Length of Pregnancy	Birth Weight	Sex	Complications	Mother's age	Hospital where born
____	_____	_____	____	_____	_____	_____
____	_____	_____	____	_____	_____	_____
____	_____	_____	____	_____	_____	_____
____	_____	_____	____	_____	_____	_____

Family: Intact _____ Single Parent _____ Divorced _____ Remarried _____

Names, ages, and gender of household members and family living in the home:

Please check off family members who reside in the child's home and list each person's name and age:

□ Mother _____ □ Father _____

□ Siblings _____; _____; _____

_____; _____; _____

□ Other _____

□ Other _____

Please list names, ages, and family living outside the home:_____; _____

_____; _____; _____

Who is the child's primary caregiver?

Who cares for the child when the primary caregiver is away? :

Mother: _____Living _____ Deceased _____ Age: _____ DOB: _____

Mother's birth place: _____

Highest grade completed: _____

Current employment: _____

How many hours away from home per day: _____

Father: _____Living _____ Deceased _____ Age: _____ DOB: _____

Father's birth place: _____

Highest grade completed: _____

Current employment: _____

How many hours away from home per day: _____

FAMILY RELATIONS

(Please check whether any of the following are present within your family)

Are their significant marital conflicts? If so briefly describe: _____

Is there conflict between child and parents? If so briefly describe: _____

Is there conflict between children? If yes, briefly describe: _____

Who disciplines the child and how?

Do parents agree on discipline?

Please explain how your child responds to discipline?

Does your child have difficulty getting along with adults?

Does your child have difficulty getting along with brothers and sisters?

Describe your child's relationship with you, his/her parents:

Describe your child's relationship with his/her siblings:

Check the activities in which the child participates with the family:

□ Movies □ Meals □ Conversations □ Visits with relatives □ Television
□ Church □ Games □ Sports □ Trips □ Other

FAMILY MEDICAL HISTORY

(Please check off whether any family members have a history of any of the following conditions. If yes, please note the child's relation to the family member with the condition in the space provided.)

- ☐ Attention Deficit/Hyperactivity
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Substance Abuse/Dependency
- ☐ Autism/Pervasive Developmental Disorders
- ☐ Learning Problems or Learning Disabilities
- ☐ Developmental Delays
- ☐ Bedwetting/Bowel Movement Witholding
- ☐ Neurological disease
- ☐ Seizures
- ☐ Hearing problems
- ☐ Visual Problems
- ☐ Slowness in walking
- ☐ Slowness in talking
- ☐ Speech Problems
- ☐ Mental retardation
- ☐ Psychiatric Hospitalization
- ☐ Difficulty with Law
- ☐ Other: (list)

Form completed by:

Relationship to child:

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