SUMMIT THERAPY & HEALTH SERVICES

CENTERED ON EXCELLENCE

Pediatric Developmental History Questionnaire

Date: _____

Child's Name: _____Age: _____Birthdate: _____

Parent/Guardian Name(s): _____

Home Phone: _____ Work Phone: _____ Email Address:_____

Primary Care Physician: _____ Date of Last Well-Child Visit: _____

Birth History:

1. Did the mother have a complicated pregnancy? ☐ Yes ☐ No
   If yes, specify: _____
2. Was the mother taking any drugs or medications during pregnancy? ☐ Yes ☐ No
3. Was the pregnancy full term? *If no, baby born at _____weeks.* ☐ Yes ☐ No
4. Was the delivery complicated? *Breech or Caesarean* ☐ Yes ☐ No
5. Was the child considered low birth weight? ☐ Yes ☐ No
   If yes, what was the baby's birth weight _____lbs _____ oz
6. Were there any complications such as:
   a. Cyanosis ☐ Yes ☐ No
   b. Jaundice ☐ Yes ☐ No
   c. Congenital Defect ☐ Yes ☐ No
   d. Other: _____
7. Was there a need for:
   a. Oxygen ☐ Yes ☐ No
   b. Transfusion ☐ Yes ☐ No
   c. Tube Feeding ☐ Yes ☐ No
8. Were there any feeding difficulties? ☐ Yes ☐ No
   Please explain: _____
9. Did the child pass the New Born Hearing Screening ☐ Yes ☐ No
   If no, please explain follow-up care and results: _____

Medical History of Child:

1. Specific diagnosed physical or mental health condition, if any _____
2. Has your child had any of the following: Check all that apply
   (*Note if Child has had immunization in space provided)*

☐ Meningitis	☐ Measles _____	☐ Chicken Pox _____
☐ High Fevers	☐ Mumps _____	☐ Whooping Cough _____
☐ Neurological Disease	☐ Infantile Colic	☐ Diabetes
☐ Seizures	☐ Heart Trouble	☐ Lung/Bronchial Difficulties
☐ Allergies	☐ Asthma	☐ Cancer

   ☐ Otitis Media (ear infection) How many _____ Treated with Antibiotics or Tubes _____

   ☐ Physical Injury/Illness requiring Hospitalization: Specify:_____
3. Has your child had a vision screening? ☐ Yes ☐ No
   If yes, when and what were the results: _____
4. Is your child on any Medications? *Please list medication and reason for taking.*

   _____

   _____

   _____

Continue on Back

Sensory System History:

1. Reacts emotionally or aggressively to touch? ☐ Yes ☐ No
2. Irritated by clothing texture or tags? ☐ Yes ☐ No
3. Picky eater, especially regarding textures? ☐ Yes ☐ No
4. Seeks all kinds of movements interfering with daily routine (fidgets)? ☐ Yes ☐ No
5. Appears not to notice, or is overly concerned, with messy face/hands? ☐ Yes ☐ No
6. Can't work with background noise like fan or refrigerator? ☐ Yes ☐ No
7. Poor endurance/ becomes tired very easily? ☐ Yes ☐ No
8. Holds hands over ears to protect ears from sounds? ☐ Yes ☐ No
9. Covers eyes or squints to protect eyes from light? ☐ Yes ☐ No

Social/Behavioral Development:

1. Does your child have difficulties with any of the following (check all that apply):

_____ Sharing with others _____ Easily following directions
_____ Transitioning between activities _____ Regulating emotions
_____ Adjusting to changes in routine _____ Playing with peers

Motor Development:

2. How old was your child when he/she:

_____ Rolled independently _____ Sat independently
_____ Crawled _____ Walked
_____ Potty trained

3. Does your child have difficulties with any of the following (check all that apply):

_____ Dressing self _____ Self-feeding small pieces of food _____ Running
_____ Puzzles/fine motor games _____ Holding a writing utensil/coloring _____ Climbing Stairs
_____ Using scissors _____ Catching a ball _____ Kicking
_____ Using silverware _____ Crawling _____ Jumping
_____ Using both hands together _____ Walking

Speech/Language Development:

1. At what age did your child first use words? _____
2. What language does your child use the most at home? _____
3. What language(s) do parent/guardians use the most when speaking with child? _____
4. Do you feel your child is experiencing difficulty with any of the following:
   a. Being understood ☐ Yes ☐ No
   b. Fluency of speech (stuttering) ☐ Yes ☐ No
   c. Voice (maintaining a "healthy" sounding voice) ☐ Yes ☐ No
   d. Explaining his/her thoughts/ideas ☐ Yes ☐ No
   e. Chewing/swallowing ☐ Yes ☐ No
   f. Other: _____ ☐ Yes ☐ No
5. Describe the difficulties related to the areas marked "Yes" and when you first noticed these difficulties :

_____

_____

General Information:

1. Has your child received therapy services in the past? *(please specify type, reason and duration)*

   _____

   _____

2. Does your child attend school/daycare? ☐ Yes ☐ No
   Where/grade: _____

3. Does your child have a current IFSP or IEP? ☐ Yes ☐ No
   IFSP=Individual Family Service Plan, IEP: Individualized Education Plan
   If yes, please indicate the School District: _____

4. What toys/activities does your child enjoy?

   _____

   _____

5. Please describe your child's strengths.

   _____

   _____

6. What would you most like to gain from this initial evaluation and/or therapy?

   _____

   _____

7. Would you like to share the results of this evaluation with a physician or agency other than the referring physician? ☐ Yes ☐ No If yes, please list: _____