

Development is CHILD'S PLAY!

AN EVALUATION AND TREATMENT CLINIC FOR CHILDREN NEEDING EXTRA HELP

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YOUNG CHILD SENSORIMOTOR HISTORY

Child's Name: _____ Date of Birth: _____ Age: _____ Sex: M/F

Name of person completing form: _____ Date: _____

Are there any physical or medical precautions or activity restrictions (e.g.: due to heart problems, asthma, seizures, physical limitations, etc.)?

Is your child currently on any medication? No _____ Yes _____

Purpose: _____

Names of medication, dosage, side effects:

Please specify significant allergies or food restrictions and note if current or previous:

Pregnancy and Birth History

Are you your child's birth/step/adoptive parent?

If not the birth parent:

Pre- and post-natal environments (e.g.: institution)?

At what age did your child come into your care?

Problems / difficulties during pregnancy:

___ bleeding ___ toxemia ___ diabetes ___ severe nausea
___ emotional stress ___ infection ___ premature labor ___ other:

How was it treated?

Labor / Delivery:

Full-term or premature? _____ Gestational age: _____ Birth weight: _____

___ fetal monitor ___ forceps ___ vacuum extraction ___ C-section
___ water broke > 24 hours before delivery ___ cord around neck ___ breech
___ meconium aspirated ___ birth injuries ___ delayed cry ___ limpness
___ other:

Neonatal:

___ oxygen required ___ jaundice ___ NICU: length of stay _____
___ difficulty nursing/poor suck ___ irritable
___ difficulty regulating temperature ___ medical intervention needed; specify:
___ other:

Developmental Milestones:

Were feeding and sleeping patterns easily established?

Fussy baby past 6 months of age? _____ Any reason identified? _____

At what age did your child consistently sleep through the night?

Indicate child's age for achieving the following skills. If uncertain, indicate early, late, or typical:

___ independent sitting ___ hands/knees crawling ___ walking
___ first words ___ sentences ___ toilet trained ___ day ___ night

Do you think that any part of your child's development is slower than average?
If yes, explain:

Current areas of concern (please mark all that apply):

- Gross Motor Development Fine Motor Development Sleeping
- Language Development Social Skills Eating
- Play Skills Temperament Attention/Focus
- Frustrations (list):
- Fears (list):
- Other:

Explain concerns:

When did you first notice your child's difficulties and how were they apparent to you?

Is there a family history of similar difficulties? If so, who, and what are the difficulties?

Please list any previous medical and/or diagnostic tests or evaluations (i.e. neurological, educational, speech/language, developmental, other) and their results. If possible, please attach copies of reports.

Significant test results:

Any diagnosis given:

Please check if your child has received services from any of the following:

- Occupational Therapy Physical Therapy Speech Therapy
- Tutoring Psychological Counseling Special Education

If so, when, where (private or school), and for how long?

Are these services ongoing?

Medical and Behavioral History

Please indicate all that are applicable and ages(s):

- High fevers Meningitis Ear infections / tubes
- Heart trouble Excessive vomiting
- Seizures Lung / bronchial difficulties
- Epilepsy Diabetes Surgery / hospitalization

Other significant accident, injury, or illness?

Mark with a "C" if this is a Current behavior or "P" if it is a behavior previously demonstrated.

- Drools excessively Resists being held Likes to cuddle
- Easy to manage Tenses when held Likes being held
- Very active Cries, fussy, irritable Distractible
- Good sleep patterns Tantrums/meltdowns Quiet or passive

Comments:

Does your child use a transitional object or security toy (bear, blanket, pacifier)?

What are your child's most preferred activities?

Indoors:

Outdoors:

What are your child's least favorite activities?

Indoors:

Outdoors:

When is your child most calm or happy?

When does your child become most frustrated?

Does your child tend to have difficulty learning new motor tasks/games?

Does your child resist participating in fine or gross motor tasks? Please explain:

Does your child have any recently acquired skills?

Check the following items that best describe your child. If it was true for your child in the past but not currently, please put a "P" rather than a check mark.

Visual

Wears glasses

Has a diagnosed visual problem (describe):

Has difficulty finding / seeing things (shoes in the closet, toy in a toy basket)

Auditory and Language

Has a suspected or diagnosed hearing loss

Limited or absence of gesturing to assist communication

Excessive talking interferes with listening

Nonverbal; Does s/he have a form of communication? List/circle the form of communication system (PECS, Sign Language, gestures used, etc.):

If language is not strong, describe the vocalizations your child uses to communicate.

Are there certain noises that your child cannot tolerate? If so, please give examples.

Oral-Motor and Respiratory Control

Displays poor lip control / lip closure for eating, drinking, using utensils

Has limited skills with blow toys, whistles, bubbles

Demonstrates poor saliva control (drools)

Chokes easily on liquids or solids. Specify:

Overstuffs mouth with food

Clenches jaw or grinds teeth

Holds breath frequently

Breathes with mouth open / often has mouth open/noisy breathing

Snores

Does your child tend to gag or cough during or just after eating?

If so, is it frequent?

Does your child have difficulty chewing different types of foods?

If so, which types?

Comments:

Daily Routines**DRESSING**

Is your child able to: (Check those which your child CAN do, circle if options)

- | | |
|---|--|
| <input type="checkbox"/> Dress/Undress | <input type="checkbox"/> Jacket on/off |
| <input type="checkbox"/> Button/Unbutton | <input type="checkbox"/> Shoes on/off |
| <input type="checkbox"/> Snap/Unsnap | <input type="checkbox"/> Zippers pull/engage/disengage |
| <input type="checkbox"/> Socks on/off | |
| <input type="checkbox"/> Notice when clothes are backwards, twisted, wet, or fasteners undone | |

Please describe how your child typically gets dressed. Include how much assistance is needed or how independent your child is with clothing, your child's behavior during dressing, and if there are types of clothing your child will not wear.

HYGIENE/GROOMING

Is your child able to:

- Allow an adult to wipe his/her face, brush teeth, brush/style hair
- Allow an adult to wash his/her hair
- Allow adult to clip nails
- Allow adult to cut hair
- Wash and dry hands at home

Please describe a typical bath time for your child. Include your child's like or dislike for bath time, your child's behavior during bath time, level of assistance needed, etc.

TOILETING

Is your child able to :

- Wipe effectively
- Manage clothes for toileting
- Get to toilet without reminders
- Wash and dry hands in a public restroom (Use varied faucets, towel dispensers, air dryers)

Do the noises in a public restroom (flushing toilets, air dryers) interfere with your child using one?

If your child has difficulty with controlling bowel and / or bladder (day or night or both), please explain:

EATING

Is your child able to:

- Remain seated for a family meal for 10 minutes (If not, how long can your child last?
_____)
- Eat liquid foods (such as soup or cereal with milk) without spilling (If not, what % is spilled?
_____)
- Use eating utensils for majority of foods
- Drink from a lidded (sippy) cup
- Drink from an open cup
- Drink from a straw
- Spread with a knife (such as jam, cream cheese, or peanut butter)
- Pour liquid into a glass without spilling
- Open a variety of food storage containers (e.g.: zip-lock bags, snap lid, screw top)

Is your child what you would describe as a "picky eater"? If so, please describe the foods your child will eat or those s/he won't eat (whichever is easier for you):

Are there foods that your family typically eats that your child will not?

Please describe a typical mealtime with your child. Include where, what and with whom your child eats, your child's typical appetite, the number of meals and snacks your child has each day, and your child's

behavior during mealtimes. Include any concerns related to limited or unhealthy diet, managing foods which are more difficult to chew, difficulty with specific types of food/textures, and tolerance of mixed textured food.

What does your child usually eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

SLEEPING

Is your child able to:

- Get himself/herself to sleep (vs. falling asleep while adult is present)
- Sleep in own bed
- Sleep through the night
- Get self back to sleep if wakes up in the night
- Awaken on own in the morning

How many hours/night does your child usually sleep?

How long does it usually take for your child to fall asleep?

Does your child have a prolonged bedtime routine?

Does your child nap/fall asleep in the daytime? If so, for how long?

Are you able to get adequate sleep? If not, what are the disruptions?

Temperament/Social

1. Does your child seem irritable at predictable times of the day? If yes, please describe the times of the day when your child seems irritable and the events that seem likely to trigger irritability.
2. Does your child seem happier or more cooperative at predictable times of the day? If yes, please describe the times of the day when your child seems happiest and most cooperative, and the events that seem likely to precede these behaviors.
3. Can your child independently settle down after periods of exciting activity or after being upset? If not, what strategies can be helpful?
4. Please describe how your child approaches and explores a new environment.
5. Does your child exhibit any repetitive, idiosyncratic, or self-stimulating patterns of behavior? If so, please describe behavior and typical situation in which it may occur.
6. Please describe your child's typical play skills. Describe your child's interaction with other children. Include information about the ages of people your child chooses to play with (same age, older, younger, only adults), if your child chooses to be a leader, a follower, or an independent player, and how many people your child is comfortable playing with at a time. What are peers' reactions to your child?

Family Resources

The family plays a primary role in developing a child's potential. This information will help us support your child's performance across environments.

Please list:

Names and ages of everyone living in the home:

Any health concerns in the family:

Others who can help care for your child or implement supplemental therapy activities (e.g.: extended family, sitters, ABA providers, etc.):

Given your needs and those of your family, how much time/energy do you and others have available to work with your child on areas of concern (e.g.: none, 1 hr./day; 2x/week, etc.)?

Are you satisfied with the level of support available to you?

On a scale of 1-10, with 1 being "not stressful" to 10 being "extremely stressful", please rate your current level of stress.

What changes would make a positive difference in your family's quality of life?

Are there family circumstances or culturally based issues that may be important for us to consider?

Summary

What things do you enjoy most about your child?

What are your main concerns about your child?

In what areas of your child's everyday functioning (dressing, eating, sleeping, hygiene, etc.) do you most want to have help?

What are the first 3 skills that you would like to see your child achieve in OT?

1.

2.

3.

Please provide any other information that you would like to share about your child.

Thank you for your time and your thoughtful responses.