

Development is CHILD'S PLAY!

AN EVALUATION AND TREATMENT CLINIC FOR CHILDREN NEEDING EXTRA HELP

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SENSORIMOTOR HISTORY

Child's Name: _____ Date of Birth: _____
Age: _____

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:

Pregnancy and Birth History

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

If not the birth parents:

Pre- and post-natal environments (eg: institution)?

At what age did the child come into your care?

Medications taken during pregnancy (name and purpose):

Problems / difficulties experienced 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 ___ NICU ___ medical intervention needed
___ irritable ___ difficulty nursing ___ poor suck
___ difficulty regulating temperature ___ jaundice ___ Other:

Developmental Milestones:

Were feeding and sleeping patterns easily established?

Fussy baby? (If so, was it due to colick and did it go beyond 6 mos. of age?)

At what age did child consistently sleep through the night?

Indicate child's age for/or if age not remembered, was milestone 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):

- | | | |
|--|---|---|
| <input type="checkbox"/> Gross Motor Development | <input type="checkbox"/> Sports | <input type="checkbox"/> Fine Motor Development |
| <input type="checkbox"/> Handwriting | <input type="checkbox"/> Pencil Grasp | <input type="checkbox"/> Language |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> Eating | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Spelling | <input type="checkbox"/> Math |
| <input type="checkbox"/> Motivation | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Neatness | <input type="checkbox"/> Organization | <input type="checkbox"/> Self-confidence |
| <input type="checkbox"/> Getting along with adults | <input type="checkbox"/> Getting along with peers | <input type="checkbox"/> Attention/focus |
| <input type="checkbox"/> Frustrations (list): | | |
| <input type="checkbox"/> Fears (list): | | |

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, speech, education, other) and their results. If possible, please attach copies of relevant reports.

Significant test results:

Any diagnosis given:

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Tutoring | <input type="checkbox"/> Psychological Counseling | <input type="checkbox"/> Special Ed. Classes |

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

Are these services ongoing?

Medical and Behavioral History

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

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Ear infections / tubes |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Excessive vomiting |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures | <input type="checkbox"/> Lung / bronchial difficulties |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Surgery / hospitalization |

Other significant accident, injury, illness?

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Drools excessively | <input type="checkbox"/> Resists being held/hugged | <input type="checkbox"/> Likes to cuddle |
| <input type="checkbox"/> Easy to manage | <input type="checkbox"/> Tense when held/hugged | <input type="checkbox"/> Likes being held |
| <input type="checkbox"/> Very active | <input type="checkbox"/> Cries, fussy, irritable, "colicky" | <input type="checkbox"/> Alert |
| <input type="checkbox"/> Good sleep patterns | <input type="checkbox"/> Irregular sleep patterns | <input type="checkbox"/> Quiet or passive |

Comments:

What are your child's most preferred activities?

Indoors:

Outdoors:

What are your child's least favorite activities?

Indoors:

Outdoors:

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:

Please describe your child's ability to independently organize and keep track of personal belongings, both at home and school.

Does your child have any newly/recently acquired skills?

Does your child demonstrate right or left-hand dominance?

Do any family members have left-hand dominance?

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 Communication

- Has a suspected or diagnosed hearing loss
- Limited or absence of gesturing to assist communication
- Excessive talking interferes with listening

If your child is nonverbal, how does he/she 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:
- Clenches jaw or grinds teeth
- Holds breath frequently
- Breathes with mouth open / often has mouth open
- Noisy breathing / snores

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"/> Velcro shoes on/off |
| <input type="checkbox"/> Snap/Unsnap | <input type="checkbox"/> Ties shoes |
| <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 | |

Approximately how much time does it take for your child to get dressed in the morning and how much assistance/reminders is/are needed from an adult?

HYGIENE/GROOMING

Is your child able to:

- Allow an adult to wipe his/her face, brush teeth, brush/style hair
- Allow an adult to his/her wash hair
- Brush teeth
- Wash/rinse self in tub or shower
- Wash and dry hands at home

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
- 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)
- Open a variety of snack-food packaging (e.g.: chip bag, bar wrapper, straw wrapper)
- Get self a snack or something to eat if hungry

Is your child what you would describe as a “picky eater”? If so, please describe the foods your child will eat or those he/she won’t eat (whichever is easier for you).

Does your child seem to crave or avoid certain kinds of foods (sweet, crunchy, sour, salty, creamy, etc.)?

Does your child tend to stuff too much food into his/her mouth?

Does your child tend to gag or cough during or just after eating? If so, is it frequent?

Please list what your child will typically eat in the following categories:

Vegetables:

Fruits:

Proteins:

Dairy products:

Grains/carbohydrates:

Fast foods:

Snacks:

Beverages:

Are there any categories of food that your child avoids or refuses?

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

COMMUNITY

Is your child able to:

- Get in and out of the car independently (including opening and closing door)
- Buckle seat belt
- Stay close to adult while walking on a sidewalk
- Avoid people and obstacles while walking in a public area
- Demonstrate awareness and avoidance of hazards in the immediate area
e.g.: others playing nearby (swings, thrown balls, running/chasing, vehicles in motion)
- cones, barricades, construction tape, etc.
- doors opening
- changes in walking surface (curbs, raised cracks, etc.)
- Participate in family activities such as extended family gatherings or visiting at relatives’ homes

Does your child have difficulty tolerating noisy or busy environments such as grocery stores, malls, or birthday parties?

PHYSICAL ACTIVITIES

How long can your child participate in a physical activity before fatiguing?

What is your child's choice of physical activity?

Outside of school, how much time does your child engage in physical activities?

Outside of school, how much time does your child participate in sedentary activities?

Does your child participate in any group or team physical activities? If so, what and how often?

Is your child able to be in close proximity to others without touching or bumping them?

Does your child engage in behaviors that may be harmful to self or others?

SLEEP

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 awakens in the night

Awaken on own in the morning

How many hours/night does your child usually sleep?

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. Can your child independently calm down after periods of exciting activity or after being upset? What strategies can be helpful?
2. Please describe how your child approaches and explores a new environment.
3. 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.
4. Does your child have friends? If so, do they tend to be the same age, older, or younger?
5. Does your child ask to have a friend come to the house?
Do friends ask to have your child come to play at their house?
If so, for what amount of time can your child participate in a "play date"?
6. When playing, does your child usually choose to be a leader, a follower, or a solitary player, and with how many people at a time is your child comfortable playing?
7. Please describe any strategies your child uses to help himself/herself sustain focused attention (e.g. chewing on pencil or shirt, shaking/bouncing leg, turn on or off background music, etc.).
8. When does your child become most frustrated?
9. 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 frustration.

10. When is your child most calm or happy? 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.

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's functioning?

What do you think hampers his/her performance?

What do you think is most helpful to him/her achieving success?

Is there any other information that you would like to share about your child?

Thank you for your information.