Pediatric Developmental History

Patient Name ______________________ Age ______ Date of Birth ___/___/_____

Person providing information ______________________

Parents'/ Caregivers' Names ______________________

Child lives with ______________________

Primary language spoken in the home ______________________

Any secondary languages ______________________

Is there a family history of any developmental delays or disorders? If so, please list below.

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Medical diagnosis ______________________

Primary concerns / reason for referral: ______________________

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Goals for therapy: ______________________

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Has your child previously had therapy or other services?

- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Audiology
- ☐ Psychological Counseling
- ______________________
- ☐ School services
- ☐ Birth to three / Headstart
- ______________________

PRENATAL AND DELIVERY

Were there any complications at or after delivery? If so please explain.

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Please check any of the following conditions that occurred during delivery:

- ☐ Anoxia
- ☐ Caesarian section
- ☐ Addiction at birth
- ☐ Jaundice
- ☐ Premature Birth (how many weeks?)

Was the child in the Newborn Intensive Care Unit? If yes, for how long? ______________

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DEVELOPMENTAL MILESTONES

Sat at age: ________ Walked at age: ________

First words at age: ________ Combined to or more words: ________

MEDICAL HISTORY

- ☐ Hospitalizations
- ☐ Surgeries
- ☐ Seizures
- ☐ Allergies
- ☐ Ear Infections
- ☐ Breathing problems/asthmas
- ☐ GERD (reflux)
- ☐ Picky Eater
- ☐ Sleeping challenges

When was last hearing evaluation? If there is a history of PE tubes or hearing devices, provide details:

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Has your child had their vision tested? If so were vision corrections recommended?

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When was the last time your child saw a dentist? ______________

Please list all medications your child is taking: ______________

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PERSONAL INFORMATION

Do you have any sensory concerns? If so please describe: ______________

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How many hours of screen time a day does your child have?
Please specify what type of screen time, and if it is supervised or independent. ______________

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Is there anything else you would like us to know about your child? ______________

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