DEVELOPMENTAL CASE HISTORY:

Child's Name: _____ Age: _____ DOB: _____ Sex: ___

Mother: _____ Age: _____ DOB: _____

Father: _____ Age: _____ DOB: _____

Family/School Information:

Does the child live with both parents? Yes or No _____

Names and ages of siblings: _____

_____

_____

Name of pre-school, daycare, or school: _____

Are you thinking of using pre-school? _____

Birth History:

Any complications during pregnancy? If so, please list_____

_____

_____

Any complications immediately following birth? If so, please list_____

_____

_____

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Medical History:

What is your main concern regarding your child:_____

_____

Is your child current with his/her immunizations: ☐ Yes ☐ No

Does your child have/had tubes: ☐ Yes ☐ No

Has your child been hospitalized for any reason? _____

_____

_____

Check all that apply: ☐ Ear Infections ☐ Tonsillitis ☐ High Fever ☐ Meningitis

☐ Seizures ☐ Allergies ☐ Measles ☐ Croup ☐ Chronic Colds

Does your child have any other illness/medical problems: _____

_____

_____

Developmental History:

List the age when your child began: Crawling _____ Walking _____

First Words _____ Combining Words _____

Did your child babble as an infant? ☐ Yes ☐ No

Feeding/Eating History:

Did your child have any difficulties feeding after birth? If so, explain _____

_____

_____

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Is your child a picky eater? ☐ Yes ☐ No

When did your child stop using the bottle? _____ Pacifier? _____

Does your child have/had a feeding tube? ☐ Yes ☐ No

If yes, please explain

_____

_____

Play/Social Information:

Does your child play appropriately with toys? ☐ Yes ☐ No

Does your child engage in any odd behaviors? ☐ Yes ☐ No

Does your child have difficulty attending or concentrating? ☐ Yes ☐ No

Does your child have any significant problems with behavior? ☐ Yes ☐ No

Sensory/Motor Development:

Does your child appear awkward or clumsy? ☐ Yes ☐ No

Does your child seem to dislike certain types of textures (Ex: Does not like getting dressed, hates tags on clothes, does not like water)? ☐ Yes ☐ No

Does your child shy away from trying new activities? ☐ Yes ☐ No

Please list dates and places of any other evaluations (Ex: DEC, neurologist, occupational therapy, ECI, etc.)_____

_____

_____