TOTAL POSS-ABILITIES, PLLC

Providing Pediatric Occupational Therapy

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Developmental History Questionnaire

Child's Name:_____ Gender:_____ Date of Birth: _____
Parent's/Legal Guardian's name(s):_____
Street Address:_____ City:_____ Zip:_____
Home #:_____ Cell #: _____
Best Daytime #: _____
Email Address: _____
Emergency/Other Contact Name:_____ Phone #:_____

Who referred you to TOTAL POSS-ABILITIES?_____
How did you hear about TOTAL POSS-ABILITIES? (Please Circle) Brochure Friend Website Doctor Other:_____
What are your concerns/reason for this visit regarding your child (Be specific)?
_____
_____

MEDICAL INFORMATION:

Your Child's Doctor/PCP:_____
Doctor's Office Phone #: _____ Doctor's Fax #: _____
Does your child have a medical diagnosis?_____
Is your child your birth child or specially chosen? (Please circle)
Were there any known complications during the pregnancy or labor/delivery?_____
_____
_____
Was mom placed on bed rest during the pregnancy? _____
Was your child premature or full term? (Please circle)
If preterm, what was his/her gestational age?_____ Length of time in NICU?_____
Birth Weight:_____ Apgar Scores (if known): _____

Did your child have difficulty nursing or taking a bottle? Yes or No
Does your child limit himself/herself to specific food textures/tastes/temperatures/etc?_____
_____
Is your child on a restricted diet? If so, what are the restrictions?_____
_____
Has your child ever had a swallow study? If so, what were the results?_____
_____

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Has your child had any of the following? (Answer Yes or No)

___Adenoidectomy	___Flu	___Sinusitis
___Allergies	___Head injury	___Sleeping difficulties
___Breathing Difficulties	___High fevers	___Thumb/finger sucking habit
___Chicken pox	___Measles	___Tonsillitis
___Colds	___Meningitis	___Tonsillectomy
___Ear infections	___Mumps	___Vision problems
___Ear tubes	___Scarlet fever	
___Encephalitis	___Seizures	

Please explain in more detail and how often: _____

_____

_____

Has your child had any significant illnesses/injuries, hospitalizations and/or surgeries? If so please explain. _____

_____

Does your child take any medications, vitamins, or supplements on a regular basis? Please list: _____

_____

Any known allergies or sensitivities? _____

Is your child currently (or have they in the past) receiving any other services?

OT: Therapist_____ Facility_____ Dates_____

PT: Therapist_____ Facility_____ Dates_____

Speech: Therapist_____ Facility_____ Dates_____

Psychology: Therapist_____ Facility_____ Dates_____

Social Group: Therapist_____ Facility_____ Dates_____

Audiologist or ENT: Doctor_____Facility_____ Dates_____

Vision Exam: Doctor_____Facility_____ Dates _____

Please bring a copy of any other evaluation/report that will help us help your child

Does your child use any special equipment for daily activities, such as:

Glasses_____ Hearing Aide_____ Splints_____ Walker_____ Wheelchair_____ Other:_____

At approximately what age did your child do the following?

Sat independently	_____	Crawled on hands and knees	_____
Walked independently	_____	Babbled	_____
Said first word	_____	Put two words together	_____
Talked in sentences	_____	Dressed self	_____
Toilet trained	_____	Undressed self	_____

Can your child currently do the following without assistance? (Answer Yes or No)

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If your child needs assistance please describe the amount needed.

Sleep through the night regularly _____
Drink from a regular cup _____
Feed self with fork and spoon _____
Use a fork and knife to cut food _____
Put on/take off socks _____
Put on/take off shirt _____
Put on/take off underwear _____
Put on/take off pants _____
Brush teeth _____
Brush hair _____
Potty trained bladder and bowel _____

Can your child manipulate:
Buttons _____
Zippers on pants _____
Zipper on coat _____
Snaps or buttons on pants _____
Shoelaces _____

Speech and Language History:

Does your child…….(Answer Yes or No)
Repeat sounds, words, or phrases over and over? _____
Follow simple one step directions ("Shut the door" or "Get your shoes")? _____
Retrieve/point to common objects upon request (Ball, cup, shoe)? _____
Respond correctly to yes/no questions? _____
Respond correctly to who/what/when/where/ why questions? _____
Does your child wave to greet others or say goodbye? _____

How does your child communicate? (Answer Yes or No)

Leading, pulling, gesturing _____
Sounds(vowels, grunting) _____
Words(shoe, doggy, up) _____
2 to 4 word sentences _____
Sentences longer than 4 words _____
Communication device _____

Do you feel as though your child has difficulty with speech? If yes, please describe. _____
_____
Has your child ever had a hearing evaluation or screening? If yes, where and when? _____
_____
What were you told?_____
Is your child aware of, or frustrated by any speech language difficulties?_____
_____

How would you describe your child? (Check all that apply)

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Cooperative_____ Attentive_____ Resistive_____ Sensitive_____ Destructive_____
Isolated_____ Social_____ Rigid_____ Short attention span _____
Impulsive_____ Difficulty with Separation_____
Does your child have any self-stimulating behaviors?_____

SCHOOL INFORMATION:

Does your child attend school or childcare? _____ If so, where? _____
_____
What grade is your child in? _____ Teacher's name: _____
Does your child have an IEP in place? _____
Is your child receiving OT, PT, or Speech through the school system? _____
If yes, what frequency? (ex. Two times per week for 30 minutes) _____
_____
If your child is currently on an IEP, please provide a copy to TOTAL POSS-ABILITIES, PLLC.

FAMILY/CHILD INFORMATION:

What are your child's living arrangements (family members, shared custody, etc.)? _____
_____
_____
_____
What motivates or interest your child (such as T.V. characters, games, candies, food, etc.)
_____
_____
_____
_____
What goals do you have OR would like him/her to be able to do that he/she is not able to do now?
_____
_____
_____
Is there anything you want me to know about your child or your family?
_____
_____
_____
_____

_____ _____
Parent or Legal Guardian's Signature Date