Today's Date ________________

Client's Name: ______________________________ ______________________________
first last

____
nickname

Parent(s)' Names:____

Birth Date: __________________________________ **Age:** __________________ **M / F**

Dear Parent, Guardian or Adult Client,

Please share with us what you hope to gain from this evaluation, therapy or consultation:

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Developmental History

Adolescent and Adult

Thank you for taking the time to fill out this history. The valuable information you share about your own struggles, accomplishments, and the goals you hope to achieve assists us in developing a comprehensive assessment and intervention plan.

Previous Testing

Please list professionals that have done evaluations and/or treatment with you and circle the letter for the type of service they provided:

Name: ______________________________ Prof: ____________________ E /T

Name: ______________________________ Prof: ____________________ E /T

Name: ______________________________ Prof: ____________________ E /T

Name: ______________________________ Prof: ____________________ E /T

Medical History:

Please indicate if you have or have had any of the following:

- ❑ Ear Infections
- ❑ Ear Tubes
- ❑ Allergies
- ❑ Asthma
- ❑ Diabetes
- ❑ Seizures
- ❑ Congenital Anomalies
- ❑ Braces/Assistive Devises
- ❑ Hearing Loss
- ❑ Visual or Ocular-Motor Problems
- ❑ ADD/ADHD
- ❑ Non-Verbal Learning Disability
- ❑ Other Learning Disabilities
- ❑ Asperger's Syndrome
- ❑ Autism Spectrum Disorder
- ❑ Obsessive-Compulsive Disorder
- ❑ Anxiety or Mood Disorder
- ❑ Cerebral Palsy
- ❑ Tourette's Syndrome
- ❑ Cognitive Delays
- ❑ Developmental Delays
- ❑ Fragile X Syndrome
- ❑ Muscular Dystrophy
- ❑ Other:__________________

Are you up to date on vaccinations? ❑ Yes ❑ No

Would you describe and clarify the above information so that we may better understand how to work with you (e.g. medical precautions, physical limitations, behavioral style, learning style):

____

____

____

____

Do you currently take any medications/ supplements?

Med: ______________________ Frequency: ____________ Purpose: ____________________

Med: ______________________ Frequency: ____________ Purpose: ____________________

Med: ______________________ Frequency: ____________ Purpose: ____________________

Supplement: _________________ Frequency: ____________ Purpose: ____________________

Supplement: _________________ Frequency: ____________ Purpose: ____________________

Birth History:

Are you adopted or in foster care? Y / N If 'Y' please specify: ________________________________

Did the mother have any of the following difficulties during pregnancy?

- ❑ Infections
- ❑ Significant Illness
- ❑ High Blood Pressure
- ❑ Spotting/ Bleeding
- ❑ Shocks or Unusual Stresses
- ❑ Premature Labor
- ❑ Gestational Diabetes
- ❑ Mandatory Bed Rest
- ❑ Other: ______________

Would you please elaborate on the complications during pregnancy (e.g. medications needed, complications during labor and delivery):

____

____

____

Did you have any of the following complications during and after delivery?

- ❑ Premature (# of Wks) ______
- ❑ Breech
- ❑ Cord Wrap
- ❑ Heart Rate Drop
- ❑ Meconium Aspiration
- ❑ Forceps Delivery
- ❑ Suction Delivery
- ❑ Cesarean Section
- ❑ Jaundice
- ❑ Apnea
- ❑ Birth Injuries
- ❑ Other: ______________

Please elaborate on these difficulties and how they were resolved (e.g. medications, procedures, ICU):

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____

Developmental History

As a baby did you experience any of the following:

- ❑ Difficulty w/ breast feeding
- ❑ Difficulty w/ bottle feeding
- ❑ Difficulty w/ baby food
- ❑ Difficulty eating soft solids
- ❑ Colic (# of Mths) __________
- ❑ Not calmed by cuddling
- ❑ Trouble settling to sleep
- ❑ Resistance to lying on belly
- ❑ Difficulty engaging socially
- ❑ Inconsolable crying
- ❑ Startled when approached
- ❑ Strong startle with noises
- ❑ Cried when lifted in the air
- ❑ Cried w/ head tipped back
- ❑ Other: ______________

What were the strategies that worked best to calm and settle you as a child?

____

____

____

As well as you can remember please tell us when you achieved the following developmental milestones: (Leave it blank if you are unsure and put N/A if they are not yet achieved):

Smiled	__________	Slept Through Night	__________	Said Words	__________
Rolled Over	__________	Fell Asleep Alone	__________	Spoke Sentences	__________
Sat Alone	__________	Stood Independently	__________	Toilet for Urine	__________
Crawled	__________	Walked	__________	Toilet for BM	__________

For the following list of functional skills please check the box that best describes your current performance. Feel free to cross out anything that is not applicable and comment on multiple items:

Can you:	Unable	With Difficulty	Accomplished	Done Easily
Manipulate closures (zippers, snaps and buttons)?	❑	❑	❑	❑
Tie shoes/ Tie a man's tie?	❑	❑	❑	❑
Blow dry hair?	❑	❑	❑	❑
Use a razor for shaving?	❑	❑	❑	❑
Use dental floss?	❑	❑	❑	❑
Blow nose?	❑	❑	❑	❑
Fall asleep easily and sleep throughout the night?	❑	❑	❑	❑
Open snacks and sodas or soft drinks?	❑	❑	❑	❑
Follow written directions (e.g. cooking recipes)?	❑	❑	❑	❑
Blow up a balloon/ Blow bubbles with gum?	❑	❑	❑	❑
Open and close an umbrella?	❑	❑	❑	❑
Cut with scissors/ Cut with a knife?	❑	❑	❑	❑
Use a blender/ Use a coffee maker?	❑	❑	❑	❑
Touch type accurately on a computer?	❑	❑	❑	❑
Catch a ball/ Kick a ball?	❑	❑	❑	❑
Ride a bicycle?	❑	❑	❑	❑
Safely cross the street?	❑	❑	❑	❑
Follow steps for aerobics, karate or gym activities?	❑	❑	❑	❑
Swim using the crawl or other strokes?	❑	❑	❑	❑
Back a car up straight/ Parallel park a car?	❑	❑	❑	❑

Please comment on any concerns you have about your development:

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Are you experiencing difficulties with daily activities? (e.g. dressing, eating, bed time routines, getting ready for school, going to the store or a restaurant, participating in social activities):

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Please describe any strategies or supports that help you with daily routines and activities:

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Please tell us about your gifts and strengths:

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What would you like to achieve?

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Social Development:

Please check any of the following items that pertain to or describe you. Feel free to add comments:

- ❑ Make friends easily
- ❑ Prefer to be alone
- ❑ Prefer to be with others
- ❑ Have trouble getting along with peers
- ❑ Prefer to sit back and let others lead
- ❑ Tend to be bossy or pushy
- ❑ Get easily frustrated
- ❑ Lack self confidence
- ❑ Have strong outbursts of anger
- ❑ Tend to be impulsive
- ❑ Tend to be cautious
- ❑ Are more often quiet and withdrawn
- ❑ Are more often active and intense
- ❑ Have anxiety or panic attacks
- ❑ Feel discouraged or depressed
- ❑ Have trouble making needs known
- ❑ Tend to be very set in your routines
- ❑ Have fear of leaving house

Additional Comments____

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Sensory History:

Please circle the number that best describes you. The scale below can be used for reference. Feel free to cross out parts of any questions that do not apply. We also appreciate your descriptive comments to give us a better sense of the specific areas of difficulty you are or have experienced in the past.

Scale: 5 = Always 4 = Frequently 3 = Sometimes 2 = Rarely 1 = Never

Visual:

Do you:		Additional Comments
Become easily distracted by visual stimulation?	5 4 3 2 1	
Get overwhelmed or disorganized by too much information on a page?	5 4 3 2 1	
Blink or become irritated by bright lights or moving objects?	5 4 3 2 1	
Ever seek out dark, quiet, or small places to when feeling bothered?	5 4 3 2 1	
Become active or grouchy after watching TV or playing on computer?	5 4 3 2 1	
Avoid, or have difficulty with eye contact?	5 4 3 2 1	
Seek visual stimulation through flicking or spinning objects?	5 4 3 2 1	
Have difficulty looking for items on a grocery shelf?	5 4 3 2 1	
Have trouble finding something in a cluttered drawer or bag?	5 4 3 2 1	
Avoid, or get frustrated with puzzles, mazes or hidden pictures?	5 4 3 2 1	
Have difficulty copying down information?	5 4 3 2 1	
Have difficulty following traffic signs while driving?	5 4 3 2 1	
Struggle with finding your way from one place to another?	5 4 3 2 1	
Have difficulty discerning facial expressions or body language?	5 4 3 2 1	
Have difficulty finding a familiar face in a crowd?	5 4 3 2 1	

Auditory:

Do you:		Additional Comments
Become distracted by background noises (e.g. fan, refrigerator)?	5 4 3 2 1	
Feel overly sensitive to certain noises? (Please specify)	5 4 3 2 1	
Negatively react to noisy, chaotic situations?	5 4 3 2 1	
Talk loudly or play music and TV on loud volume?	5 4 3 2 1	
Have difficulty correctly identifying sounds?	5 4 3 2 1	
Have trouble understanding words to a song or what an announcer says?	5 4 3 2 1	
Have trouble following 2-3 step verbal directions (given at once)	5 4 3 2 1	

Scale: 5 = Always 4 = Frequently 3 = Sometimes 2 = Rarely 1 = Never

Smell and Taste:

Do you:		Additional Comments
Feel overly sensitive to certain smells? (Please specify)	5 4 3 2 1	
React defensively to the taste and textures of foods (please specify)	5 4 3 2 1	
Have a limited food repertoire? (Please list foods & flavors you eat)	5 4 3 2 1	
Tend to explore through smell; deliberately smells objects?	5 4 3 2 1	
Lick, suck, mouth or chew on non-food items? (Please specify)	5 4 3 2 1	
Lack awareness in and around your mouth (e.g. messy eater)?	5 4 3 2 1	

Touch:

Do you:		Additional Comments
Feel overly sensitive to tags or seams in clothes?	5 4 3 2 1	
Strongly dislike haircutting or shampooing?	5 4 3 2 1	
Dislike fingernail or toenail cutting, or feel it hurts?	5 4 3 2 1	
Have a strong preference for temperature of water and foods?	5 4 3 2 1	
Avoid touching textured mediums (e.g. hair products, raw meat, sand)?	5 4 3 2 1	
Feel bothered by clothes: need to pull at, adjust, or remove them?	5 4 3 2 1	
Have strong clothing preferences? (Please describe)	5 4 3 2 1	
React strongly to being touched unexpectedly?	5 4 3 2 1	
Feel discomfort with, or avoid having people close to you?	5 4 3 2 1	
Become overly irritated when splashed with water?	5 4 3 2 1	
Tend to be more sensitive to pain than others?	5 4 3 2 1	
Crave pressure (e.g. hugs, tight clothes, heavy blankets, pillows)?	5 4 3 2 1	
Ever pinch, bite, or otherwise hurt self? (Please specify)	5 4 3 2 1	
Feel the need to handle and touch objects thoroughly?	5 4 3 2 1	
Frequently drop items if not watching hands?	5 4 3 2 1	
Have awkward control with hands; feel like you are wearing gloves?	5 4 3 2 1	
Have difficulty finding objects in your pocket or purse without looking?	5 4 3 2 1	
Tend not to feel pain as much as others?	5 4 3 2 1	

Scale: 5 = Always 4 = Frequently 3 = Sometimes 2 = Rarely 1 = Never

Body Awareness:

Do you:		Additional Comments
Get over stimulated with negotiating through crowds of people?	5 4 3 2 1	
Seek 'heavy work' such as cleaning, jumping or pushing heavy objects?	5 4 3 2 1	
Seek input to mouth through chewy, crunchy foods or stuffing mouth?	5 4 3 2 1	
Find physical activity organizing when overloaded or irritated?	5 4 3 2 1	
Tend to bump or push others either by accident or on purpose? (Specify)	5 4 3 2 1	
Not understand personal space and often get too close to others?	5 4 3 2 1	
Have trouble judging body movement in space; frequently bump into things?	5 4 3 2 1	
Have difficulty grading amount of force (in hugs, writing, petting cat)?	5 4 3 2 1	
Grasp objects too tightly; or spill and break things more than expected?	5 4 3 2 1	

Movement:

Do you:		Additional Comments
Frequently experience motion sickness in cars, trains, boats, etc.?	5 4 3 2 1	
Feel fearful of, or avoid swings and amusement park rides?	5 4 3 2 1	
Hesitate or avoid climbing or going down stairs, ladders, ramps, bridges?	5 4 3 2 1	
Become upset with head motion (e.g. lying backward, moving elevator)?	5 4 3 2 1	
Dislike escalators, elevators, or going through tunnels? (Please specify)	5 4 3 2 1	
Become disoriented easily or feel disconnected from gravity?	5 4 3 2 1	
Feel most happy when engaged in movement activities?	5 4 3 2 1	
Seek strong movement through spinning, rocking, head banging, etc.?	5 4 3 2 1	
Feel the need to be in constant motion, have trouble sitting still?	5 4 3 2 1	
Enjoy being upside down with head in an inverted position?	5 4 3 2 1	
Have difficulties with activities requiring balance (e.g. bike riding)?	5 4 3 2 1	
Fall when a bus or subway stops quickly?	5 4 3 2 1	
Fall or trip more often than others your age?		
Have difficulty discriminating the speed and direction of movement?	5 4 3 2 1	
Feel surprised when you fall (e.g. unexpectedly falling out of chair)?	5 4 3 2 1	
Have trouble driving a car (e.g. going straight, turning corners, merging)	5 4 3 2 1	

Scale: 5 = Always 4 = Frequently 3 = Sometimes 2 = Rarely 1 = Never

Motor Coordination:

Do you:		Additional Comments
Have articulation difficulties making it hard to understand you?	5 4 3 2 1	
Keep mouth open most of the time or chew with mouth open?	5 4 3 2 1	
Have an awkward grasp with a pencil or pen?	5 4 3 2 1	
Find small manipulative/ fine motor activities difficult?	5 4 3 2 1	
Struggle, easily fatigue or have difficulty with handwriting?	5 4 3 2 1	
Grimace or move tongue while doing fine motor tasks?	5 4 3 2 1	
Seem weaker than other people your age?	5 4 3 2 1	
Tend to fatigue easily with physical activity (Poor endurance)?	5 4 3 2 1	
Slump, stand or move in and out of the chair while doing work?	5 4 3 2 1	
Take a long time to do most motor tasks?	5 4 3 2 1	
Feel reluctant to participate in sports and games?	5 4 3 2 1	
Have difficulty copying or maintaining rhythms?	5 4 3 2 1	
Take longer than other people to learn and master new motor tasks?	5 4 3 2 1	
Have difficulty planning a dinner or packing for a vacation?		
Struggle with motor tasks that have several steps?	5 4 3 2 1	
Feel inconsistent in motor skills (e.g. can do it one day, but not next?)	5 4 3 2 1	

School and Work Performance:

Please check off any areas that you feel you struggle with in school and at work:

- ❑ Sitting still
- ❑ Paying attention
- ❑ Following directions
- ❑ Working independently
- ❑ Organizing work
- ❑ Finishing work
- ❑ Social interactions
- ❑ Following the rules
- ❑ Group activities/ meetings
- ❑ Unscheduled, unexpected events
- ❑ Reading
- ❑ Writing/ Spelling
- ❑ Math
- ❑ Tool use
- ❑ Other: ____________________

What extracurricular activities do you participate in? ____

____

____

Signature of Person(s) Completing Form:____

Relationship to Client: ____

Compiled by S. Szklut MS, OTR/L with significant contributions from OTA-Watertown's Developmental History