



**5. Prenatal/Birth History**

During the pregnancy did the mother use/have: drugs \_\_\_\_\_ alcohol \_\_\_\_\_ cigarettes \_\_\_\_\_  
illness \_\_\_\_\_ accidents \_\_\_\_\_ medications \_\_\_\_\_ any other difficulties \_\_\_\_\_

Labor was Normal/Other (if other, please explain) \_\_\_\_\_

Delivery was Normal/Other (if other, please explain) \_\_\_\_\_

Full Term \_\_\_\_\_ Premature \_\_\_\_\_ Birth weight \_\_\_\_\_

Were there any medical problems or complications with the baby at birth? Yes No

How long was the baby hospitalized? \_\_\_\_\_

**6. Medical History**

Is your child subject to frequent colds, sore throats, or ear infections? (explain frequency and treatment) \_\_\_\_\_

Has your child had tympanostomy tubes inserted? \_\_\_\_\_

Has your child had any serious illnesses, operations, or injuries? (explain) \_\_\_\_\_

Does your child have allergies?  food  medication  environmental

History of asthma? \_\_\_\_\_ Bronchopulmonary Dysplasia? \_\_\_\_\_ Reactive Airway Disease? \_\_\_\_\_

Sinus Problems? \_\_\_\_\_ Nasal Discharge? \_\_\_\_\_

Is your child a mouth breather? \_\_\_\_\_ Does your child drool? \_\_\_\_\_

Current medications \_\_\_\_\_

History of skin rashes? \_\_\_\_\_

Vision problems? \_\_\_\_\_ Last vision test date \_\_\_\_\_ Eye glasses \_\_\_\_\_

Hearing problems? \_\_\_\_\_ Last hearing test date \_\_\_\_\_ Hearing aids? \_\_\_\_\_

Does your child wear/use orthopedic appliances? \_\_\_\_\_ AFO \_\_\_\_\_ Braces \_\_\_\_\_ Wheelchair \_\_\_\_\_

Other health problems \_\_\_\_\_

Pediatrician's Name/Phone # \_\_\_\_\_

**7. Developmental Milestones**

Please list appropriate ages for the following (if child does not perform this skill, write "not yet"):

Sit up alone \_\_\_\_\_

Drink from a cup \_\_\_\_\_

Crawl \_\_\_\_\_

Weaned from bottle \_\_\_\_\_

Walk \_\_\_\_\_

Feed self \_\_\_\_\_

First words \_\_\_\_\_

Toilet trained \_\_\_\_\_

Combined words \_\_\_\_\_

Wash own hands \_\_\_\_\_

Put on own jacket \_\_\_\_\_

Does your child?

- Match colors
- Match simple shapes/patterns
- Complete simple inset puzzles

Does your child understand concepts of:

- Empty/full
- Little big
- Over/under

### 8. Speech/Language

Circle the following sounds that your child can make at this time:

M B P N F V G K W L S Z CH SH J R TH

Did, or does the child (include age when applicable):

- |  |   |
|--|---|
| <u>Age</u>   | <u>Age</u>  |
| <input type="checkbox"/> _____ Babble  | <input type="checkbox"/> _____ Attempt to imitate speech            |
| <input type="checkbox"/> _____ Use jargon (jabber without saying real words) | <input type="checkbox"/> _____ Never used his/her voice             |
| <input type="checkbox"/> _____ Vocalize for pleasure                         | <input type="checkbox"/> _____ Acquire speech and then stop talking |
| <input type="checkbox"/> _____ Communicate by crying/laughing/smiling        | <input type="checkbox"/> _____ Have a "language of his/her own"     |
| <input type="checkbox"/> _____ Use gestures meaningfully                     | <input type="checkbox"/> _____ Uses sign language                   |

Which is/are his/her most frequent means of communication? \_\_\_\_\_ looking at objects \_\_\_\_\_ gestures \_\_\_\_\_ pointing at objects \_\_\_\_\_ physical manipulation \_\_\_\_\_ sounds \_\_\_\_\_ words \_\_\_\_\_ phrases \_\_\_\_\_ complete sentences

How old was your child when he/she used his/her first meaningful word, other than "mama" or "dada"?

Does your child ask questions? \_\_\_\_\_

Can your child follow one-step and two-step directions? \_\_\_\_\_

Does your child have difficulty pronouncing any sounds? \_\_\_\_\_ If so, which ones? \_\_\_\_\_

Can parents understand his speech? \_\_\_\_\_ Relatives? \_\_\_\_\_ Playmates? \_\_\_\_\_ Teachers? \_\_\_\_\_

### 9. Motor Development

**Gross Motor:** Does your child:

- Seem awkward and uncoordinated?
- Fall and/or lose balance easily?
- Walk up and down stairs independently?
- Jump from a bottom step?
- Balance on one foot (at least 5 seconds)?
- Catch a ball using their arms sitting/standing?

**Fine Motor:** Does your child?

- Mark with crayons
- String beads
- Build a tower with blocks? How many high? \_\_\_\_\_
- Snip paper with scissors?
- Imitate drawing lines? \_\_ vertical strokes  
\_\_ horizontal strokes \_\_ circular strokes

### 10. Self Help Development

Does your child sit in a chair to eat? \_\_\_\_\_ Eat with the rest of the family? \_\_\_\_\_ Eat solid foods? \_\_\_\_\_ Eat semi-solid foods? \_\_\_\_\_ Eat pureed foods? \_\_\_\_\_ Eat baby foods? \_\_\_\_\_

Is there any difficulty in swallowing? \_\_\_\_\_ Chewing? \_\_\_\_\_

Can your child feed himself/herself? \_\_\_\_\_ With fork? \_\_\_\_\_ With spoon? \_\_\_\_\_ With hands? \_\_\_\_\_

Can your child drink liquids independently? \_\_\_\_\_ Use a straw? \_\_\_\_\_ Use a sipper cup? \_\_\_\_\_ Bottle? \_\_\_\_\_  
Requires some assistance drinking (describe) \_\_\_\_\_  
Does he/she require specialized equipment for feeding? \_\_\_\_\_  
Additional concerns \_\_\_\_\_

**Toileting Skills:** Does your child initiate the need to use the toilet? \_\_\_\_\_

Check those items that your child is able to do without any assistance.

- locate bathroom
- unfasten pants
- pull down pants
- sit on toilet
- uses toilet paper properly
- pull pants up
- adjust clothing
- flush toilet

**Social Habits**

- needs to sit
- defecates in pants (how often?) \_\_\_\_\_
- requires assistance to sit or remain seated
- wears diapers
- uses trainer potty chair
- wets bed at night (how often?) \_\_\_\_\_
- uses adapted toilet seat or other devices \_\_\_\_\_
- requires catheterization
- wets pants during day time hours (how often?) \_\_\_\_\_

**11. Socialization**

Does your child interact with other children on a regular basis? (siblings, daycare, preschool, babysitter, playgroup)

Check all that apply:

- interacts well with children
- interacts well with adults
- attentive
- cooperative
- tries new activities
- separation difficulties
- easily frustrated/agitated
- poor eye contact
- aggressive
- withdrawn
- destructive
- self-abusive behavior
- inappropriate behaviors (please list): \_\_\_\_\_

**12. General Information**

What are your child's strengths? \_\_\_\_\_

What are your child's favorite toys and activities? \_\_\_\_\_

Does your child have any significant fears? \_\_\_\_\_

**13. Previous School/Preschool Attended:**

Name of School: \_\_\_\_\_

Phone #: \_\_\_\_\_ Contact Person: \_\_\_\_\_