INTEGRATED CHILDREN'S THERAPIES, INC.
where children make connections

DEVELOPMENTAL/SENSORY HISTORY

Ages birth – 3 years

Parents: This history may appear to be quite long. However, a number of the questions require checking off responses, which can be done quickly. This information is very useful in gaining a clear understanding of your child's strengths and weaknesses. We appreciate your time.

Person Completing History: ☐Mother ☐ Father ☐ Self ☐ Other (specify) ___________________________

General Information:

Child's Full Name:____ Birth Date:___________________

Address:____ Gender: male______female______

____ Phone #:____________________

Child's Race: ☐ Caucasian ☐ African Am. ☐Hispanic ☐Asian ☐Native Am. ☐Other (specify) ______________

Is child adopted? ☐Yes ☐No Foster Child? ☐Yes ☐No

Parents are: ☐married ☐separated ☐divorced ☐widowed ☐single ☐other (specify) _______________

Parent's Name:__________________________________ Relation to Child:__________________________

Occupation:_____________________________________ Employer:_________________________________

Phone #:

Parent's highest education completed: ☐less than high school ☐high school grad ☐some college/associates

☐bachelors ☐ post-graduate ☐doctoral/post-doctoral

Parent's Name:__________________________________ Relation to Child: __________________________

Occupation:_____________________________________ Employer:_________________________________

Phone #:

Parent's highest education completed: ☐less than high school ☐high school grad ☐some college/associates

☐bachelors ☐ post-graduate ☐doctoral/post-doctoral

Names and ages of brothers and sisters:____

Emergency Contact Person:____

(Name) (Relationship) (Phone #)

Teacher's Name:___________________________________School:___________________________________

Grade in School:___________________Type of classroom:____

Referred by (name, address, profession):____

Please provide child's **current**: Height: ________Weight: ________

Handedness (hand they use to write or eat): ☐ Right ☐ Left

Medical Information:

Child's Physician and other Professionals: (continue on back of page if needed)

Physician: ______________________ Address: ___________________________ Phone: ___________________

Other: _________________________ Profession: _________________________ Phone: ___________________

Other: _________________________ Profession: _________________________ Phone: ___________________

Other: _________________________ Profession: _________________________ Phone: ___________________

Medical Diagnosis:

_____ ADD/ADHD _____ Anxiety Disorder or Mood Disorder, specify: ________________________

_____ Autism _____ Cognitive Delay

_____ Down Syndrome _____ Emotional Disorder, specify: _____________________________________

_____ Fragile X Syndrome _____ Learning Disabilities, specify if possible: ____________________

_____ Tourette's Syndrome _____ Non-Verbal Learning Disability

_____ Pervasive Developmental Disorder (PDD)

_____ Other, specify: ____

Has child received previous evaluation and/or treatment by an occupational therapist?________________________

If yes, when and where:____

Has child had a vision test?____________ If yes, when?____

Has child had a hearing test?__________ If yes, when?____

What were the results of hearing and vision tests?____

Has your child had any of the following? If yes, describe and give approximate dates.

Childhood diseases or major illnesses:____

Congenital abnormalities:____

Surgery:____

Serious injury:____

Casts or braces:____

Ear infections:____

Tubes in ears:____

Allergies:____

Seizures:____

Other:____

List any medications your child is **currently** taking, its purpose and frequency of the dosage:

Medication: ______________________ Purpose: ________________________ Freq. of dosage: ______________

Medication: ______________________ Purpose: ________________________ Freq. of dosage: ______________

Medication: ______________________ Purpose: ________________________ Freq. of dosage: ______________

Medical information continued:

Has your child received any medications **in the past** for any of the above-mentioned conditions?

Medication: ______________________ Purpose: ________________________ Dates Taken: ________________

Medication: ______________________ Purpose: ________________________ Dates Taken: ________________

Medication: ______________________ Purpose: ________________________ Dates Taken: ________________

Are there any medical **precautions** the therapist should be aware of when working with your child?

____

____

Does your child have any assistive devices (e.g., glasses, casts, wheelchair)?_______________________________

____

Has your child received other evaluations or treatment (school, psychological, private therapist or clinic, neurology, nutritionist, GI consult, allergist, etc.)? If so, what type, when, and by whom?

Type Eval. Date Professional's Name Dates of therapy

____

____

____

____

____

What do you hope to gain from this evaluation and/or treatment?_____________________________________

____

____

____

Mother's Health During Pregnancy:

Did the mother:

1) have any infections/illnesses during pregnancy? ☐Yes ☐No

Describe:____

2) have any shocks or unusual stresses during pregnancy? ☐Yes ☐No

Describe:____

3) receive any medication during pregnancy? ☐Yes ☐No

If yes, what kind:____

4) any complications during delivery/labor? ☐Yes ☐No

Describe:____

Child's Birth:

Was or did child:

1) full term ☐Yes ☐No Weight at birth:

2) premature ☐Yes ☐No Number of weeks:______________________________

3) breech (feet first) ☐Yes ☐No

4) require forceps for delivery: ☐Yes ☐No

5) require suction for delivery: ☐Yes ☐No

6) have any birth injuries: ☐Yes ☐No

Describe:____

7) If known, Apgar score at one minute:__________at five minutes:_____________

8) require intensive care hospitalization: ☐Yes ☐No

If yes, for how long?____

9) jaundiced? ☐Yes ☐No Length of treatment____

Infancy and Early Childhood:

Did your child:

1) have feeding problems? ☐Yes ☐No If yes, describe:______________________________

____

2) have sleeping problems? ☐Yes ☐No If yes, describe:______________________________

____

3) have colic? ☐Yes ☐NoIf yes, for how long?_________________________

4) prefer certain positions as an infant? ☐Yes ☐No If yes, describe:_____________________

____

5) dislike lying on stomach? ☐Yes ☐No

6) dislike lying on back? ☐Yes ☐No

7) enjoy bouncing? ☐Yes ☐No

8) become calmed by car rides or infant swings? ☐Yes ☐No

9) become nauseated by car rides or infant swings? ☐Yes ☐No

10) go through "terrible twos"? ☐Yes ☐No

If no, describe your child's toddler stage:____

____

____

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Developmental Milestones:

(Give approximate ages if remembered, or comment on anything unusual)

Rolling over______________ Walk_________________________ Say words___________________

Sit alone_________________ Chew solid food________________ Say sentences_______________

Crawl___________________ Drink from a cup_______________

Was crawling phase brief? ☐Yes ☐No Absent? ☐Yes ☐No

Did child use a walker (rolling plastic seat)? ☐Yes ☐No If yes, how often?__________________________

Experience hesitancy or delays in learning to go down stairs? ☐Yes ☐No

What concerns you most about your child?

Are there problems with any daily routines?

Please tell us about your child's strengths and gifts.

What in particular would you like your child to achieve?

How, if in any way, would you like to interact differently with your child?

Sensory History:

Please check the appropriate area, comment as desired, and cross out any parts of questions which do not apply to your child. Please refer to the scale below when answering.

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Visual-Spatial Processing:

	Does child:						Comments
1	become easily distracted by visual stimulation?	5	4	3	2	1	
2	dislike having eyes covered?	5	4	3	2	1	
3	like playing in the dark?	5	4	3	2	1	
4	tend to draw some numbers and letters backwards?	5	4	3	2	1	
5	blink at bright lights or seem irritated by them?	5	4	3	2	1	
6	have difficulty following objects with their eyes?	5	4	3	2	1	
7	dislike having head covered with a blanket?	5	4	3	2	1	
8	avoid or have difficulty with eye contact?	5	4	3	2	1	

10 have a favorite color? ☐ Yes ☐ No What color(s)?________________________________

Is the child strongly attracted to this color? ☐Yes ☐No

Auditory and Language Processing:

	Does/is child:						Comments
1	dislike listening or singing to music?	5	4	3	2	1	
2	have difficulty maintaining or copying rhythms?	5	4	3	2	1	
3	at times, seem not to understand what is said?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Auditory and Language Processing continued:

4	seem overly sensitive to sounds?	5	4	3	2	1	
5	become distracted by lots of noise?	5	4	3	2	1	
6	become distracted by background noises such as refrigerators, fluorescent lights, fans, etc.?	5	4	3	2	1	
7	seem to have trouble remembering what was said?	5	4	3	2	1	
8	have speech or articulation difficulties?	5	4	3	2	1	
9	have trouble expressing what he/she wants?	5	4	3	2	1	
10	unable to follow two or three directions given at once?	5	4	3	2	1	
11	Enjoy making strange noises or make noises for noise sake?	5	4	3	2	1	

Movement:

	Does child:						Comments
1	dislike swings?	5	4	3	2	1	
2	prefer to swing in an infant swing?	5	4	3	2	1	
3	enjoy being spun around as on a swing?	5	4	3	2	1	
4	dislike being tipped upside down or lifted overhead?	5	4	3	2	1	
5	hesitate or avoid climbing on equipment such as jungle gyms?	5	4	3	2	1	
6	hesitate or have difficulty going down stairs?	5	4	3	2	1	
7	seem fearful of catching balls?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Movement continued:

8	fearful when laid back for diaper changes?	5	4	3	2	1	
9	walk on toes?	5	4	3	2	1	
10	jump a lot on beds or other surfaces?	5	4	3	2	1	
11	bang head on purpose?	5	4	3	2	1	
12	rock in bed or while sitting?	5	4	3	2	1	
13	seem to have poor balance?	5	4	3	2	1	
14	become carsick easily?	5	4	3	2	1	
15	afraid of sitting on a tall chair with feet off the floor?	5	4	3	2	1	
16	dislike laying on surface higher than a bed?	5	4	3	2	1	
17	dislike rocking chairs (by self or in an adult's lap)?	5	4	3	2	1	
18	becomes upset if head is tilted backwards as in hair washing?	5	4	3	2	1	
19	dislike walking on uneven surfaces, e.g., pillow on floor?	5	4	3	2	1	
20	fearful of elevators?	5	4	3	2	1	
21	take movement or climbing risks that compromise personal safety?	5	4	3	2	1	
22	falls asleep easily in a car?	5	4	3	2	1	

Taste and Smell:

	Does child:						Comments
1	tend to explore with smell, deliberately smell objects?	5	4	3	2	1	
2	react defensively or seem overly sensitive to some odors?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Taste and Smell Continue:

3	react defensively to the taste and texture of many foods?	5	4	3	2	1	
4	act as though all food tastes the same?	5	4	3	2	1	
5	have more difficulty eating textured than smooth foods?	5	4	3	2	1	
6	prefer crunchy textured foods?	5	4	3	2	1	
7	Gag easily with food textures, smells, or eating utensils?	5	4	3	2	1	
8	Have difficulty eating smooth foods with a few lumps (e.g., soup)?	5	4	3	2	1	
9	Lick, suck or chew on non-food items (past 18 months)? What items (write in "comments").	5	4	3	2	1	

10 What foods does the child prefer?____

Touch (Tactile Processing):

	Does child:						Comments
1	seem excessively ticklish?	5	4	3	2	1	
2	become irritated by tags in the back of shirts?	5	4	3	2	1	
3	prefer to touch rather than be touched?	5	4	3	2	1	
4	strongly dislike haircutting or shampooing?	5	4	3	2	1	
5	dislike fingernail or toenail cutting?	5	4	3	2	1	
6	tend to examine objects by touching thoroughly with hands? (2 years +)	5	4	3	2	1	
7	have difficulty petting animals, may use too much force?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Touch (Tactile Processing) continued:

8	complains if socks aren't on correctly?	5	4	3	2	1	
9	seem to crave being held and cuddled?	5	4	3	2	1	
10	dislike being touched unexpectedly?	5	4	3	2	1	
11	tend to prefer long sleeves and pants regardless of weather?	5	4	3	2	1	
12	dislike cloth of certain textures?	5	4	3	2	1	
13	avoid getting hands into paste, finger paints, or messy things?	5	4	3	2	1	
14	often seem overly active?	5	4	3	2	1	
15	tend to bump or push others?	5	4	3	2	1	
16	tend to be more sensitive to pain than others?	5	4	3	2	1	
17	become especially bothered by small cuts?	5	4	3	2	1	
18	tend not to feel pain as much as others?	5	4	3	2	1	
19	seem oblivious to bruises and heavy falls?	5	4	3	2	1	
20	tend to remove shoes whenever possible?	5	4	3	2	1	
21	complain that others often hit or push him or her?	5	4	3	2	1	
22	pinch, bite or otherwise hurt self?	5	4	3	2	1	
23	complain about irritating bumps on the bed sheets?	5	4	3	2	1	
24	over or under-dress for the temperature?	5	4	3	2	1	
25	overheat easily?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Touch (Tactile Processing) continued:

26	become upset when coming out of a bath?	5	4	3	2	1	
27	become extremely irritated when splashed with water?	5	4	3	2	1	
28	mouth objects or clothing frequently?	5	4	3	2	1	
29	seem overly sensitive to food or water temperature?	5	4	3	2	1	
30	dislike hand and face washing?	5	4	3	2	1	
31	dislike hugs and cuddling?	5	4	3	2	1	
32	dislike having hand held by an adult or other children?	5	4	3	2	1	
33	dislike tooth brushing?	5	4	3	2	1	
34	dislike waring band-aids or stickers?	5	4	3	2	1	

Social:

	Does child:						Comments
1	make friends easily?	5	4	3	2	1	
2	tend to prefer to play alone?	5	4	3	2	1	
3	have a strong desire for sameness and routine?	5	4	3	2	1	
4	tend to crave attention?	5	4	3	2	1	
5	seem sensitive to criticism?	5	4	3	2	1	
6	lack self-confidence?	5	4	3	2	1	
7	have strong outbursts of anger, tantrums?	5	4	3	2	1	
8	have trouble getting along with other children?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Social continued:

9	have trouble getting along with other children?	5	4	3	2	1	
10	tend to be quiet and withdrawn?	5	4	3	2	1	
11	tend to lack carefulness, be impulsive?	5	4	3	2	1	
12	tend to be relaxed and patient?	5	4	3	2	1	
13	tend to be intense, easily frustrated?	5	4	3	2	1	
14	tend to be in perpetual motion?	5	4	3	2	1	
15	tend to have difficulty separating from parents?	5	4	3	2	1	
16	tend to be very set in her or his routines?	5	4	3	2	1	
17	prefer the company of adults to children?	5	4	3	2	1	
18	hit or bite other children?	5	4	3	2	1	
19	seems discouraged or depressed?	5	4	3	2	1	

Motor Skills:

	Does child:						Comments
1	have difficulty with motor tasks that have several steps?	5	4	3	2	1	
2	approach new motor activities in an overly cautious manner?	5	4	3	2	1	
3	avoid drawing activities?	5	4	3	2	1	
4	frequently bump into objects, people, etc?	5	4	3	2	1	
5	seem shaky when doing fine motor tasks?	5	4	3	2	1	
7	seem weaker than others age?	5	4	3	2	1	

Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Motor Skills continued:

8	frequently grasp objects very tightly?	5	4	3	2	1	
9	tend to break many objects?	5	4	3	2	1	
10	drop things easily?	5	4	3	2	1	
11	tire easily with physical activity?	5	4	3	2	1	
12	appear to enjoy falling on purpose?	5	4	3	2	1	
13	tend to eat in a sloppy manner?	5	4	3	2	1	
14	find small manipulative activities difficult?	5	4	3	2	1	
15	prefer playground to table activities?	5	4	3	2	1	
16	prefer table activities to playground activities?	5	4	3	2	1	
17	perform movements in a slow and plodding fashion?	5	4	3	2	1	
18	take a long time to do most motor tasks?	5	4	3	2	1	
19	appear reluctant to participate in sports and games?	5	4	3	2	1	
20	tend to move in and out of chair while eating or doing work?	5	4	3	2	1	
21	feel heavier when lifted than anticipated?	5	4	3	2	1	
22	tire easily, especially when standing or sitting upright?	5	4	3	2	1	
23	slump while sitting?	5	4	3	2	1	
24	have difficulty with handling eating utensils?	5	4	3	2	1	
25	frequently spill liquids?	5	4	3	2	1	

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Scale: 5-Always 4-Often 3-Sometimes 2-Rarely 1-Never

Motor Skills continued:

26	drool?	5	4	3	2	1	
27	keep mouth open most of the time?	5	4	3	2	1	
28	have trouble chewing?	5	4	3	2	1	
29	have difficulty giving a kiss?	5	4	3	2	1	
30	have difficulty getting in and out of a car seat?	5	4	3	2	1	
31	have difficulty getting in and out of a highchair?	5	4	3	2	1	
32	seems to be a "dare devil", unaware of safety concerns?	5	4	3	2	1	

Developmental Skills (please circle those items in a specific category that your child can not do):

Ease of Performance:

	Does your child:	Unable 1	Poor 2	Some difficulty 3	Average 4	Good 5	Above average 6
1	sit independently?	1	2	3	4	5	6
2	walk independently?	1	2	3	4	5	6
3	walk up and down stairs?	1	2	3	4	5	6
4	climb on playground equipment?	1	2	3	4	5	6
5	throw a ball?	1	2	3	4	5	6
6	catch a ball?	1	2	3	4	5	6
7	propel a riding toy with feet?	1	2	3	4	5	6
8	ride a tricycle or a Big Wheel?	1	2	3	4	5	6
9	pick up small objects with fingers?	1	2	3	4	5	6
10	stack rings on a ring stand?	1	2	3	4	5	6
11	turn pages of a book?	1	2	3	4	5	6
12	stack blocks?	1	2	3	4	5	6
13	complete single piece puzzles?	1	2	3	4	5	6

Developmental Skills Continued (please circle those items in a specific category that your child can not do):

Ease of Performance:

	Does your child:	Unable 1	Poor 2	Some difficulty 3	Average 4	Good 5	Above average 6
14	complete interlocking puzzles?	1	2	3	4	5	6
15	color with crayons?	1	2	3	4	5	6
16	draw lines and circles?	1	2	3	4	5	6
17	string beads?	1	2	3	4	5	6
18	finger feed self?	1	2	3	4	5	6
19	drink from a cup?	1	2	3	4	5	6
20	feed self with a spoon?	1	2	3	4	5	6
21	feed self with a fork?	1	2	3	4	5	6
22	hold arms and legs up for dressing?	1	2	3	4	5	6
23	unzip a jacket?	1	2	3	4	5	6
24	remove jacket?	1	2	3	4	5	6
25	undress self? (shoes, shirt, pants, socks, underwear)	1	2	3	4	5	6
26	put on/take off shoes?	1	2	3	4	5	6
27	put on underwear, socks, shoes, shirt, pants?	1	2	3	4	5	6
28	unbutton large buttons?	1	2	3	4	5	6
29	blow soap bubbles?	1	2	3	4	5	6
30	blow whistles?	1	2	3	4	5	6
31	drink from a straw?	1	2	3	4	5	6
32	kick a ball?	1	2	3	4	5	6

Bowel and Bladder:

Does or did child:

1) Is your child toilet trained? ☐Yes ☐No

2) At what age did your child?

a) indicate discomfort of soiled pants? ________

b) anticipate need to eliminate? ________

c) indicate need to use toilet? ________

d) begin toilet training? ________

3) Does or did your child:

a) continue to have accident during the day? ☐Yes ☐No

if no, trained at what age? ______

b) continue to have accident during the night? ☐Yes ☐No

if no, trained at what age? ______

c) seem fearful of sitting on the toilet? ☐Yes ☐No

Sleep Patterns:

Does child:

1) have regular sleep patterns? ☐Yes ☐No If no, describe:________________________________

____

2) wake frequently during the night? ☐Yes ☐No If yes, describe:________________________________

____

3) tends to be an early riser, up and on the go? ☐Yes ☐No

4) have a difficult time falling asleep? ☐Yes ☐No

5) tend to sleep through outings, e.g., at the mall, playground? ☐Yes ☐No

Play Skills:

1) What are your child's favorite play things?________________________________

____

2) What does she or he do with these toys?________________________________

____

3) Who does child prefer to play with?________________________________

____

4) What activities does the child least enjoy?________________________________

5) Are there any things that your child tends to fear or avoid? ☐Yes ☐ No

If yes, describe:________________________________

6) How long does child play with one toy?________________________________

7) Does your child tend to play while in one position more than others do? ☐Yes ☐No

If yes, what position?____

8) Does your child tend to play with things by lining them or piling them up (if over two years of age)?

☐Yes ☐No Describe:____

9) What extra-curricular activities are your child involved in (i.e., gymnastics, swimming lessons, Scouts, etc.)?

____

____

Do you or anyone else in your family have similar difficulties to your child's? If so, please describe below and/or mark pertinent sections of the questionnaire in a second color. If similar difficulties do exist, how have they affected your life or the lives of other family members? (Attach an additional page if desired.)

____ ____________

Signature Date