



Sensory and Developmental History

Name: _____ **Date:** _____
 Last First Middle Month Day Year

Mother's Name: _____ **Father's Name:** _____

Email Address: _____

Child's Physician: _____

During the Past six months, has the child been seen by:

If yes, please explain reason for visit(s):

Medical Doctor:	YES	NO	_____
Ear, Nose & Throat Doctor	YES	NO	_____
Psychiatrist/Psychologist	YES	NO	_____
Neurologist	YES	NO	_____
Physical Therapist	YES	NO	_____
Occupational Therapist	YES	NO	_____
Speech Therapist	YES	NO	_____

Is your child seeing any other specialist? If so, whom and for what?

Please list any medical conditions your child has been diagnosed with:

Please list any medications (prescribed or over the counter) your child is currently taking:

List any allergies you child has (food and environmental):

Please indicate, describe, and provide approximate dates for the following pertaining to your child:

Casts, Braces, Orthotics, Hand Splints: _____

Childhood disease or major illness: _____

Congenital Abnormalities: _____

Ear Infections: _____

Injections (Botox, phenol, or other): _____

Seizures: _____

Serious Injury: _____

Surgery: _____

Tubes in Ears: _____

Any other Special Equipment: _____

Other: _____

Please list medical precautions (if any) regarding your child and therapy:

Were there any complications with pregnancy, labor, or delivery? Please explain.

Full Term or Premature? (Check one)

Number of weeks: _____

Weight at Birth: _____

Small for gestational age: YES NO

Breech (feet first): YES NO

Required forceps for delivery? YES NO

Required vacuum for delivery? YES NO

Birth Injuries: YES NO

Please explain: _____

Required Intensive Care Hospitalization? YES NO

If yes, length of treatment: _____

Jaundiced? YES NO

If yes, length of treatment: _____

Provide the approximate ages (when possible) or comment on anything usual for the following:

Rolling over: _____

Sits Independently: _____

Crawling: _____

Walks: _____

Drinks From Cup: _____

Says Words: _____

Chews Solid Foods: _____

Was Crawling Phase Brief? YES NO **Absent?** YES NO

Does or did your child experience hesitancy or delays in learning to go down stairs? YES NO

At what age was your child toilet trained? _____

Does your child continue to have accidents during the day? YES NO

Does your child continue to have accidents at night? YES NO

Does your child have regular sleep patterns: YES NO

Please describe: _____

Tend to be an earlier riser, up and on the go? YES NO

Have a difficult time falling asleep? YES NO

Need to have an adult present to fall asleep? YES NO

Sleep in his/her own bed? YES NO

Does your child dislike any types of sensations (touch, noise, lights, movement)? Does he or she seem to seek out any particular sensations?

Does your child have any visual or hearing deficits? Have they had a hearing or vision evaluation? If yes, when?

Does your child have any feeding/swallowing problems? Problems eating or drinking?

(Sucking, chewing, drooling, or gagging)

Does your child have any difficulty with daily skills? (Dressing, buttons, snaps, shoe tying, eating, using utensils, etc).

Please describe your child's normal routine (wake-up time, naps, eating habits, favorite toys).

Describe the child's problem and when it was first noticed. What are your concerns?

What particular skills would you like this child to achieve in the next six months?

Additional Comments/Information:

Signature of Parent or Guardian:

(Signature Implies consent to treatment)

Date: