Web: therayouth.org Email: elizabeth@therayouth.org Phone: 908-662-1000

Developmental History

Please help us learn more about your child and family by filling out the Developmental History Form for our records and review.

Patient First Name – *Required*

Patient Last Name – *Required*

Developmental History

Person Completing Form: – *Required*

☐ Parent 1: ☐ Parent 2: ☐ Self ☐ Other (specify below):

Parent/Caregiver Information – *Required*

☐ Parent 1 Name:

☐ Parent 1 Occupation:

☐ Parent 1 Contact Phone Number:

☐ Parent 2 Name:

☐ Parent 2 Occupation:

☐ Parent 2 Contact Phone Number:

Sibling(s):

Names:
Ages:

Is your child adopted?

- [ ] Yes
- [ ] No

If your child is adopted, at what age and from where?

Is your child a foster child?

- [ ] Yes
- [ ] No

School Information: – *Required*

Child's school name:
Grade:
Teacher's name:
Type of classroom:

Does your child have and Individualized Education Plan (IEP)? – *Required*

- [ ] Yes
- [ ] No

Medical Information:

Other professionals involved in the child's care

Primary Care Physicial Name:

Tel:

IMPORTANT **Does your child have a condition which may require immediate or emergency care and treatment (seizures, allergies, behavioral issues, etc.). Are there any precautions that the therapist should be aware of?** *– Required*

Diagnoses (if any):

Has your child had a recent vision test? What were the results?

- [ ] Yes
- [ ] No

Has your child had a recent hearing test? What were the results?

- [ ] Yes
- [ ] No

Does your child use adaptive equipment (glasses, hearing device, orthotics, etc.)? Please specify:

- [ ] Yes
- [ ] No

Medications (please list current and past medications):

Medication:
Dose:
Frequency:
Date:

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

- [ ] Childhood disease
- [ ] Major illness
- [ ] Congenital abnormalities
- [ ] Surgery
- [ ] Serious injury
- [ ] Ear infections
- [ ] Seizures
- [ ] Allergies
- [ ] Concussion
- [ ] Frequent falls
- [ ] Other (please specify):

Has your child received any of the following evaluations or treatment? Please list Provider/Facility Name and Approximate Dates

- [ ] Occupational therapy

- [ ] Speech therapy

- [ ] Physical therapy

- [ ] Vision therapy

- [ ] Behavioral therapy (ABA, DIR)

- [ ] Psychotherapy

- [ ] Neuropsychological services

- [ ] Nutritionist

- [ ] Counseling

- [ ] Other (please specify):

Tell us about your child:

What are your child's strengths and special gifts? *– Required*

What are your child's favorite interests and play activities?

What concerns you most about your child? – *Required*

Do your child's difficulties affect the rest of your family? If yes, how?

What particular skills would you like your child to achieve in the next six months? – *Required*

Does anyone in your family have difficulties similar to your child?

Early History:

Did the mother have any stresses/illnesses during pregnancy?

- [ ] Yes
- [ ] No
- [ ] Unsure

If yes, please describe:

Was the mother prescribed medication during the pregnancy?

- [ ] Yes
- [ ] No
- [ ] Unsure

If yes, please describe:

Were there complications during labor or delivery?

- [ ] Yes
- [ ] No
- [ ] Unsure

If yes, please describe:

Was the child full term?

- [ ] Yes
- [ ] No
- [ ] Unsure

If not, how many weeks gestation:

Type of delivery?

- [ ] Vaginal
- [ ] Cesarean section (scheduled)
- [ ] Cesarean section (unscheduled)
- [ ] Scheduled induction

Birth weight

Did the child require specialized treatment or nursery care after birth?

- [ ] Yes
- [ ] No
- [ ] Unsure

If yes, please describe:

As an infant, did your child have any problems with feeding, sleeping, or self-soothing?

- [ ] Yes
- [ ] No

If yes, please describe:

Please note the approximate age when your child achieved the following Motor, Developmental and Language skills:

Rolling:
Sitting (unsupported):
Crawling:
Walking:

Motor Skills:

Please check if your child is independent with the following motor skills and provide comments:

- [ ] Jump with two feet
- [ ] Hop on one foot
- [ ] Pump a swing
- [ ] Ride a tricycle

- [ ] Ride a bicycle (without training wheels)

- [ ] Climb playground equipment

- [ ] Walk up the stairs alternating feet

- [ ] Walk down the stairs alternating feet

- [ ] Gallop

- [ ] Skip

- [ ] Write his/her name

Daily Routines:

Does your child have any issues with sleeping? (difficulty falling or staying asleep, irregular sleep)

- [ ] Yes
- [ ] No
- [ ] Unsure

If yes, please describe:

Does your child have any issues with toileting? (constipation, accidents, etc.)

- [ ] Yes
- [ ] No
- [ ] Unsure

If yes, please describe:

Does your child have any issues with dressing or hygiene? (too slow, needs help more than other kids his/her age, etc.)

☐ Yes ☐ No ☐ Unsure

If yes, please describe:

Does your child have any issues with feeding? (picky eater, not feeling hungry, etc.)

☐ Yes ☐ No ☐ Unsure

If yes, please describe:

Does your child have any issues with play or social skills?

☐ Yes ☐ No ☐ Unsure

If yes, please describe:

Academic and Outside School Activities

Child's handedness

☐ Right ☐ Left ☐ Ambidextrous ☐ No hand preference

What extracurricular activities is your child involved in? (i.e. gymnastics, swimming, Scouts, etc.)

Check any areas that your child is considered to have difficulty with in the classroom environment:

- [ ] Reading
- [ ] Physical Education
- [ ] Following directions
- [ ] Restlessness
- [ ] Writing
- [ ] Art
- [ ] Finishing tasks
- [ ] Organizing work
- [ ] Spelling
- [ ] Music
- [ ] Initiating work
- [ ] Memory/recall
- [ ] Math
- [ ] Recess/Playground
- [ ] Focus
- [ ] Other (describe below)

Please describe these difficulties:

Please share any additional information not included in this developmental history that you think may help us in evaluating and treating your child:

We appreciate you taking the time to complete this intake form in order to help us provide the best possible treatment plan of care for your child and family.

You are welcome to share with us how you heard about KidLink Therapy as we would like to acknowledge the recommendation:

Signature

Date