Child's Medical and Developmental History Form

Patient Name_____ **DOB:** _____
Referred by: _____

Parent or Guardian concerns: _____

Pregnancy/Delivery

Pregnancy Proceeded: ◯ Without Complication ◯ With Complication

□ Eclampsia	□ Pre-eclampsia	□ Polyhydramnios
□ Gestational Diabetes	□ Premature Labor	□ Toxemia
□ Multiple Births	□ Substance Exposure	□ IUGR
□ Other:		

Length of Pregnancy (in weeks) _____ Prenatal care was: ◯ Received ◯ Not Received

Delivery Proceeded: ◯ Without Complication ◯ With Complication

□ Abruptio Placenta	□ Occiput Posterior Position (Face Up)	□ Prolapsed Cord
□ Breech Presentation	□ Non-Progressive/Unproductive Labor	□ Use of Forceps
□ Low Birth Weight	□ Premature Rupture of Membranes	□ Uterine Rupture
□ Negative Vacuum	□ Umbilical Cord Wrapped Around Neck	□ Traverse Presentation
□ Placenta Previa		□ Signs of Fetal Distress
□ Other		

Delivery

Delivery was: ◯ Vaginal ◯ C-Section ◯ Emergency C-Section Length of child's hospital stay:_____

Birth Hospital: _____

Needed to be transferred to another hospital or NICU: ◯ YES ◯ NO

Transfer Hospital: _____ Length of stay: _____

Birth Weight: _____ Birth Height: _____ Apgar 1 min_____ 5 min_____ 10min_____

Additional details of birth: _____

Complications Following Birth

□ Cytomegalovirus	□ Respiratory Complications	□ Intrauterine Growth Retardation (IUGR)
□ Positive Tox Screen	□ Meconium Aspiration	□ IVH Bleed Grade I, II, III, or IV
□ Feeding Difficulties	□ Cardiac Defect	□ Retinopathy of Prematurity (ROP)
□ Oxygen Requirement	□ Prematurity	□ Hyperbilirubinemia (Jaundice)
□ Other:		

Current Medical Diagnoses	Date Diagnosed

Current Medications

Allergies

Current Vitamins

Immunizations

Up to date on immunizations: ◯ YES ◯ NO

Received annual flu shot (if child is greater than 6 months of age): ◯ YES ◯ NO

Do you have any questions related to immunizing your child and/or the annual flu shot? ◯ YES ◯ NO

Please share your questions and further information will be provided by the nursing staff at Boyer: _____

Hearing Test

□ Never Tested, No Concerns
□ Never Tested, Have Concerns
Normal Test Results on Newborn Hearing Screen: □ YES □ NO
Normal Test Results on additional hearing evaluations: □ YES □ NO

Last Test Date: _____

Results: _____

Vision Test

□ Never Tested, No Concerns
□ Never Tested, Have Concerns
□ Normal Test Results
□ Abnormal Test Results

Last Test Date: _____

Results: _____

Concerns: _____

Current Medical Providers			
Name	**Specialty**	**Reason**	**Date of last visit**
	Primary Care Provider		

Diagnostic Tests		
Test	**When**	**Details/Results**
Biopsy		
Blood Work/Lab Tests		
CT Scan		
ECHO		
EEG		
MRI		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-Ray		
Other:		

Hospital Admissions		
Type	**Date**	**Results/Details**

Previous Developmental Assessments or Therapy Evaluations		
Type	**Date**	**Results/Details**

Developmental History

Play and Motor Development

Please describe any motor and/or play concerns: _____

Is the child able to:	Began at age (in months)
Come to sitting from a lying position	
Creeping or crawling alone	
Grabbing a toy	
Holding head up alone	
Pulling self to standing position	
Rolling over	
Sitting alone without support	
Standing unsupported	
Walking with support	
Walking unaided	

How does child get around the house? _____

Favorite Toys/Play Activities: _____

Descriptions of Child

□ Active	□ Cautious	□ Distractible	□ Insecure	□ Playful
□ Affectionate	□ Curious	□ Fearful	□ Motivated	□ Shy
□ Aggressive	□ Demanding	□ Fearless	□ Passive	□ Stubborn
□ Calm	□ Difficult to comfort	□ Fussy	□ Persistent	□ Withdrawn
□ Other				

Social/Emotional Skills (please select all that apply)

□ Is easily distracted	□ Prone to emotional outburst	□ Only plays with adults
□ Calms self easily	□ Doesn't allow others to join play	□ Prefers to play alone
□ Gets angry/frustrated easily	□ Has difficulty making friends	□ Has difficulty with separations
□ Is aggressive toward others	□ Plays with peers	□ Has poor eye contact

Please describe any social-emotional or behavioral concerns: _____

Self Regulation (please select all that apply)

☐ Avoids getting messy	☐ Seeks out (craves) stimulating sounds
☐ Seeks out (craves) touch or movement	☐ Resists certain movements (e.g. bouncing, swinging, upside down)
☐ Stumbles or falls frequently	☐ Has difficulty figuring out how to move body or takes more time with movements
☐ Appears awkward or less coordinated	☐ Does not tolerate certain textures (e.g. clothing surfaces, foods)
☐ Flaps hands	☐ Uses lots of pressure when touching someone or holding an object
☐ Allows brushing of teeth	☐ Has difficulty transitioning from one activity to another
☐ Bangs on surfaces, bangs hits head	☐ Has difficulty falling asleep
☐ Fatigues quickly	☐ Has difficulty remaining asleep through the night
☐ Has self-abusive behaviors	☐ Appears lethargic/sleepy all the time
☐ Resists certain tasks or environment	☐ Has poor sense of body in space, runs into things
☐ Spins things or self	☐ Seeks support for posture (e.g. leans on furniture, walls or people, holds head
☐ Is sensitive to lights, sounds or noise	☐ Demonstrates stiff or rigid movement patterns
☐ Sleeps a lot	☐ Hyper focused (on specific tasks, people, objects, etc.)
☐ Resists touch	☐ Other Please describe:
☐ Walks on toes	
☐ Lines up items or toys	
☐ Seeks out (craves) visually stimulating objects	

Feeding

Please describe any feeding problems: _____

_____

_____

Food Likes: _____

Food Dislikes: _____

☐ Breast Feeding ☐ Bottle Feeding Formula: _____

Number of feedings per day: _____ How many ounces per feeding: _____

Weaned from breast and/or bottle feeding at age: _____

Current Feeding Adaptions

☐ Thickened liquids Consistency:_____

☐ Calorie Supplements Details: _____

☐ Tube Feeding Formula: _____Amount: _____Times per day: _____

☐ Continuous ☐Bolus

Feeding Milestones			
Milestone	**Age began (in months)**	**Milestone**	**Age began (in months)**
Using a bottle		Using a straw	
Using a pacifier		Stopped using a bottle	
Eating baby food		Stopped using a pacifier	
Eating junior food		Using utensils to eat	
Eating table food		Holding own bottle/cup	
Drinking from a cup		Self-feeding	
Drinking from a sippy cup			

Areas of difficulty

□ Chewing	□ Swallowing	□ Jaw shifts/slides/juts	□ Drooling
□ Communication Needs	□ Transitioning between foods	□ Understanding words	

Speech Language

Please describe current speech concerns: _____

Communication Skills		
Does this child ?	**YES**	**NO**
Have speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

Speech Milestones			
Milestone	**Age began (in months)**	**Milestone**	**Age began (in months)**
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

First Words: _____

Primary Communication

☐ Verbal ☐ Non-Verbal ☐ None

Methods of communication used:

☐ Vocalizations	☐ 2 word phrases	☐ Facial Expressions	☐ Manual Sign Language	☐ Pointing
☐ Single Words	☐ Complete Sentences	☐ Body Language	☐ Gestures	☐Eye Gaze

Home Environment

Type of Home

☐ Single Level ☐ Ground Floor Apartment ☐ Other: _____

☐ 2 Level ☐ Upper Level Apartment

Languages spoken at home ☐ English ☐ Other: _____

Childs Legal Guardian: _____

Primary care taker of child during day: _____

Please list all adults that live in home

NAME	RELATIONSHIP TO CHILD	LANGUAGE SPOKEN

Please list all children who live in your home

NAME	GENDER	BIRTHDATE	GENERAL HEALTH

Peer Opportunities:

Does your child have peer opportunities outside of the home? ◯ **YES** ◯ **NO**

Describe any community groups or activities in which your child is involved.

_____

_____

Does your child attend daycare or preschool? ◯ YES ◯ NO Times/Days: _____

Daycare/Preschool name and address: _____

_____

Daycare/Preschool Contact Person: _____

Early Intervention Services

Has or is your child receiving any Early Intervention Services, education services, or therapy services?

◯ YES ◯ NO If yes, please specify:

Service	Type	Status	How often	Where

Family Medical History

Please list any hereditary diseases, developmental delays, disabilities; as well as vision and hearing conditions in any family members.

MOTHER'S FAMILY	
Relationship to Child	**Problem**
1.	
2.	
3.	

FATHER'S FAMILY	
Relationship to Child	**Problem**
1.	
2.	
3.	

_____ _____ _____

Name of Person Completing this Form Relationship to Child Date