Creative Communication for Kids – Penni Siemens, M.S. CCC/SLP
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DEVELOPMENTAL HISTORY

Note: Please read and answer these questions as completely and accurately as possible. They are important for helping the therapist to understand your child and provide appropriate treatment. Feel free to add any additional comments or information on the back of this form.

CHILD'S NAME: _____ Birthdate: _____

Today's Date: _____ Child's Age: _____

Address: _____
street city state zip

Home Phone: _____

Parents are: _____ married _____ living apart
If living apart, who is the primary legal custodian? _____
Is there a court order that specifies the consent of BOTH parents is necessary for health care decisions? _____yes _____no

MOTHER'S NAME: _____
Address (if different from child's): _____
Phone: _____ _____ _____
Home Work Cell/Pager
Employer: _____ E-mail: _____

FATHER'S NAME: _____
Address (if different from child's): _____
Phone: _____ _____ _____
Home Work Cell/Pager
Employer: _____ E-mail: _____

Language(s) spoken in the home: _____

Siblings/Other Immediate Family Living in the Home or Seen Frequently:

Name	*Age*	*Relationship to child*

HISTORY OF PROBLEM
Does your child already have any medical or educational diagnosis?

_____ _____
diagnosis **diagnosed by** (name or agency) **date**

Has your child ever received an evaluation or therapy from any of the following professionals? Please write "no" or if yes, please specify who and when.

Speech Therapist (SLP) _____
Occupational or Physical Therapist (OT/PT) _____
Psychologist, Educational Therapist, Learning Consultant _____
Applied Behavioral Analysis or Discrete Trial (ABA/DT) _____
Neurologist _____
Audiologist (hearing tested?) _____

How would you describe your child's difficulties:

Does he/she have any behavior or attention problems not already described above?

When did you first become concerned about your child?

What do you think the cause might be?

How does your child's development compare with his/her siblings or playmates?

Is there a family history of any language or learning difficulties? (If yes, describe):

How does your child communicate his/her needs to you (if not talking)?

Does the family understand the child?
Do others understand the child?
What do you do if you cannot understand your child?

SCHOOL HISTORY

Does your child have an IEP through the school district? ____Yes _____ No
School District: _____
School attending: _____
Teacher: _____ Grade : _____
Does your child receive any of the following services through the school district:
Special day class? (describe type) _____
Speech therapy? _____
Resource Specialist? _____
Occupational Therapy? _____
APE? _____
ABA? _____
Other? _____

Teacher's concerns: _____

Child's favorite subjects/activities: _____

Disliked subjects/activities: _____

BIRTH & MEDICAL HISTORY

PEDIATRICIAN'S NAME: _____ Phone: _____

Is your child adopted? If yes, at what age? _____ From what country? _____

Birthweight: _____ Length: _____ Duration of Pregnancy: _____
Type of delivery (please circle): normal / elective C-section / emergency C-section / forceps / breech / other
Any complications & treatment: _____

Has your child ever experienced (please circle): seizures / frequent colic / jaundice sleep difficulty / feeding difficulty / other _____

Serious Illnesses, Accidents, Surgeries (especially allergies, ear infections, strep throat, tonsillectomy, head injuries, PE tubes):

Illness	*Date*	*Illness*	*Date*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current medications: _____

Is your child on a special diet? (gluten-free, casein-free, ketogenic, Feingold, etc.) _____

_____

Any alternative or complementary medical treatments? _____

DEVELOPMENTAL HISTORY

Approximate age your child did the following (if you can't remember ages but think it was within the right age range, please write OK):

Crawled _____ Pulled to Standing _____ Walked Alone _____

Drank from Cup _____ Fed Self with Utensils _____

Babbled _____ Said Words_____ Used Phrases_____

Please describe your child's gross motor skills (e.g. ability to walk, run, throw, catch, climb, bike, etc.): _____

Please describe your child's fine motor skills (e.g. ability to draw, write, cut. do puzzles or pegs, use utensils, etc.): _____

Please list your child's strengths: _____

_____

Please list your child's weaknesses: _____

_____

What age children does your child most enjoy playing with (please circle all that apply: plays alone / adults / same age / younger / older / siblings only

SENSORIMOTOR HISTORY *(please circle all that apply)*

Does your child have difficulty with utensils / scissors / crayons and pencils / buttons / zippers / puzzles ?

Does your child have difficulty with walking / running / jumping / stairs / dressing self / throwing / catching / riding bike ?

Does your child stumble or fall frequently? yes / no

Does your child dislike water / sand / hugs / touch (e.g. putting on lotion, tapping arm for attention, etc.) ?

Is your child picky about clothing textures? yes / no

Does your child dislike listening to music / singing / stories / noisy places ?

Does your child have difficulty following directions? yes / no

Does your child now or has previously had difficulty swallowing / drinking ?

Is your child a picky eater? yes / no

Does your child exhibit distractible or short attention span / cry or tantrum often / dislike changes / aggressive / shy / difficulty sleeping / overly active ?

By signing below, you signify that you are the legal guardian or parent with the lawful right to make healthcare decisions regarding this child and you accept financial responsibility for services.

Parent Signature: _____ **Date:** _____

Parent Name (printed): _____