WILD ROOTS
THERAPY

Date:_____

Developmental History
Early Childhood

General Information

Child's Name:_____
(first) (last) (nickname)

Birth Date:_____ Phone #:_____

Address:_____

City/State/Zip:_____

Mother's Name:_____ Occupation:_____

Employer:_____ Phone #:_____

Father's Name:_____ Occupation:_____

Employer:_____ Phone #:_____

Names and ages of children and other adults in the home:_____

_____

Emergency Contact Person (name, relationship, phone #):_____

_____

Referred by (name, address, profession):_____

_____

Does your child attend: ☐Nursery School/Preschool:_____

☐ Early Intervention Program:_____

Child's Physician (name, address, phone #):_____

Medical Information

Has your child received previous evaluation and/or treatment by an occupational therapist? ☐Yes ☐ No

If yes, when and where:_____

Medical diagnosis (if any):_____

Has child had a vision test? ☐Yes ☐ No If yes, when? _____

Has child had a hearing test? ☐ Yes ☐ No If yes, when?_____

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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?:_____

Allergies:_____

Seizures:_____

Other:_____

List any medications your child is currently receiving and frequency of dosages:_____

_____

_____

Has your child received medications in the past for any of the above-mentioned conditions? ☐ Yes ☐ No

If yes, what and when?_____

_____

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

□Yes □No_____

Does your child have any assistive devices (such as glasses, casts, or wheelchair)? ☐ Yes ☐ No

_____

Has your child received other evaluations or treatment (psychological, speech and language, neurology)?

☐ Yes ☐ No If so, what type, when, and by whom?

Type	EvaI. Date	Professional's name	Dates of therapy

_____

_____

_____

_____

Mother's Health during Pregnancy

Did the mother:

1. have any infections/illnesses during pregnancy? □Yes □No

   Describe:_____

2. use of alcohol, tobacco prescription or non prescription drugs? □Yes □No

   Describe (amount/ frequency):_____

3. have any shocks, unusual stresses, multiple moves, verbal/emotional/physical abuse during pregnancy? □Yes □No

   Describe:_____

4. have 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. small for gestational age (SGA)? □Yes □No
4. breech (feet first)? □Yes □No
5. require forceps/suction for delivery? Injuries? □Yes □No

Describe: _____

6. require intensive-care hospitalization? □Yes □No How long?_____
7. jaundiced? □Yes □No Length of treatment _____
8. When and to whom did the child go home to?

   _____

Infancy and Early Childhood

Does or 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 □No 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. tend to always be generally compliant? ☐Yes ☐No

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

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

11. Moves: with whom and where did the child live:_____

_____

_____

_

Developmental Milestones

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

Rollover	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 How often?_____

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

Did child climb out of crib independently? ☐Yes ☐No If yes, at what age? _____

BOWEL AND BLADDER

1. Is your child toilet-trained? ☐Yes ☐No
2. At what age did your child:
    - indicate discomfort of soiled pants? _____
    - anticipate need to eliminate? _____
    - indicate need to use toilet? _____
    - begin toilet training? _____
3. Does or did your child:
    - continue to have accidents during the day? ☐Yes ☐No

      If no, trained at what age? ____

- continue to have accidents during the night? □Yes □No

  If no, trained at what age? ____

- seem fearful of sitting on 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. tend to be an early riser, up and on the go? □Yes □No
4. have a difficult time falling asleep? □Yes □No
5. changes to sleep patterns:_____

PLAY SKILLS

1. What are your child's favorite play things? _____
2. Who (people) does your child prefer to play with? _____
3. What activities does the child least enjoy? Fears?_____
4. How long does child play with one toy? _____
5. Does your child tend to play while in one position more than others? □Yes □No

   If yes, what position?_____
6. What extra-curricular activities is your child involved in (such as gymnastics, swimming lessons, etc.)?_____

Goals for the next six months? (Motor, Social, Emotional/Behavior)

_____

_____

_____

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

Adverse Childhood Experiences Screen

Prior to age 18:

1. Verbal Abuse or Emotional Abuse
2. Sexual Abuse
3. Physical Abuse
4. Physical Neglect
5. Emotional Neglect
6. Parents Separate or Divorce
7. Mother abused in the home
8. Chemical dependency of parent/caregiver
9. Mental illness, depression, suicide attempt of parent or caregiver
10. Household member go to prison

Add up child's "yes" scores:_____

Add up caregivers "yes" score:_____

The CDC's Adverse Childhood Experiences Study (ACE study) uncovered a stunning link between childhood trauma and the chronic diseases people develop as adults, as well as social and emotional problems. This includes heart disease, lung cancer, diabetes and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide.

We are using these scores to direct therapy and referrals for a more multidisciplinary approach and so we are not missing trauma factors as we work with children and their families.