WILD ROOTS
THERAPY

Date:_____

Developmental History
School-Age Child

Parents: This history may appear to be quite long. However, a number of the questions require checking off responses, which can be done quickly. This information is very useful in gaining a clear understanding of your child's strengths and weaknesses. We appreciate your time.

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 in the home:_____

_____

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

_____

Referred by (name, address, profession):_____

_____

Did 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):_____

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

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

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 in ears:_____

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 or tobacco?

□Yes □No

Describe (amount/ frequency:_____

3. Any use of prescription or non-prescription medications:_____

4. have any shocks or unusual stresses during pregnancy? Domestic violence? Moves? Instability □Yes □No

Describe:_____

5.. 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 for delivery? □Yes □No
6. require suction for delivery? □Yes □No
7. have any birth injuries? □Yes □No

Describe: _____

8. If known, Apgar score at one minute: _____at five minutes:_____
9. require intensive-care hospitalization? □Yes □No How long?_____
10. jaundiced? □Yes □No Length of treatment _____
11. Who did child go home to from hospital?_____

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. become nauseated by car rides or infant swings? □Yes □No

10. tend to always be generally compliant? □Yes □No

11. go through "terrible twos"? □Yes □No

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

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

Does or did your child:

1. have trouble learning urinary control? □Yes □No

2. have trouble learning bowel control? □Yes □No

3. continue to have accidents during the day until what age_____

4. continue to have accidents during the night until what age_____

5. seem to have difficulty registering the need to eliminate? □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

PLAY SKILLS

1. What are your child's favorite play things? _____

_____

2. What does the child do with these toys?_____

_____

3. Who does your child prefer to play with? _____

_____

4. What activities does the child least enjoy?_____

_____

5. Are there any things which your child tends to fear or avoid? □Yes □No

   If yes, describe:_____

6. How long does child play with one toy? _____

7. Does your child tend to play while in one position more than others? □Yes □No

   If yes, what position?_____

8. Does your child tend to play with things by lining them or piling them up (if over two years of age)? □Yes □No

   Describe: _____

9. What extra-curricular activities is your child involved in (such as gymnastics, swimming lessons, etc.)?_____

_____

_____

_____

SCHOOL SKILLS

If enrolled in school, is your child considered to have difficulty in any of the following? (Check those that apply.)

□ Reading
□Math
□Spelling
□ Handwriting
□ Following directions
□ Other:

□ Finishing tasks
□ Remembering information
□ Paying attention
□ Organizing work
□ Restlessness

1. What are your child's favorite subjects in school?_____

_____

2. What are your child's least favorite subjects?_____

_____

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

_____

_____

_____

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

_____

_____

_____

Parental Concerns

Please describe the major concerns you have regarding your child's development (motor, sensory, emotional) in order of importance to you.

1. (most important)_____

2._____

3._____

4._____

5._____

Adverse Childhood Experiences Checklist

Prior to age 18 did child experience:

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.