



# Bothell Pediatric and Hand Therapy

## Developmental History Form

Please fill out as completely as possible the following information regarding your child's developmental history. This information will assist us in completing our initial assessment of your child and developing a treatment plan. Please feel free to ask for assistance if necessary.

Child's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex:  Male  Female      DOB: \_\_\_\_\_

Form filled out by:  Mother  Father  Other \_\_\_\_\_

### School

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

Regular Education Program     Special Education Program

Is your child on an IEP? \_\_\_\_\_

### Medical History Information

#### Physician Information:

Primary Care Physician: \_\_\_\_\_

Name/Clinic Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number (    ) \_\_\_\_\_

### Medications:

Name	Amount (e.g mg)	Frequency	Reactions	Reason for taking

Medications cont.

Are there any restrictions, side effects or information regarding medication that directly relates to your child's safety?

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Birth and Developmental History

Were there any health problems during pregnancy?

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Other than prenatal vitamins, were there any other medications taken during pregnancy?\_\_\_\_\_

Pregnancy was:  Full term  Premature:\_\_\_\_\_weeks

Delivery was:  Normal  Caesarean  Forceps  Other

Were there any complications following delivery?

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Were all developmental milestones met on time?  Yes  No (explain)

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At what age did your child:

Sit up unassisted\_\_\_\_\_

Crawl\_\_\_\_\_

Potty trained\_\_\_\_\_

Speak 1 word\_\_\_\_\_

Walk independently\_\_\_\_\_

Run\_\_\_\_\_

Eat with utensils\_\_\_\_\_

2-3 words\_\_\_\_\_

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Please list any medical conditions that your child may have:

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Has your child ever been hospitalized:

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Please list any health conditions your child experiences:

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**Daily Functioning**

Eating:  Normal  Area of concern

Sleep Cycle:  Normal  Area of concern

Elimination:  Normal  Area of concern

Dressing:  Independent  Area of concern

Play Skills:  Independent  Area of concern

**Language**

Languages Spoken:  English  Other\_\_\_\_\_

Easily Understood:  Yes  No

Receptive Language (ability to understand what is being said):

Normal  Area of concern

Expressive Language (ability to speak):

Normal  Area of concern

**Previous Testing**

Vision:  Yes  No Date Tested\_\_\_\_\_

Hearing:  Yes  No Date Tested\_\_\_\_\_

Ear Infections  Tubes in ears

Intelligence:  Verbal  Performance  Full Scale  N/A

**Services Currently Receiving:**

Services	Frequency	Location (e.g school vs. private)
<input type="checkbox"/> Occupational Therapy		
<input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Speech and Language		
<input type="checkbox"/> Psychology		
<input type="checkbox"/> Psychiatry		
<input type="checkbox"/> Nutrition		
<input type="checkbox"/> Vision Therapy		

**Goals**

Who referred you to BPHT?

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What are your concerns for your child? What brings you to seek an assessment?

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What do you hope to achieve from our services?

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What are your child's strengths?

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Is there anything else that you would like us to know about your child?

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