Developmental History & Intake Information

Parents, We want to make sure your child gets the most out of every therapy session. We appreciate the time you take to answer the questions below.

Today's date:____
Child's name:____
Date of birth:____
Child's Diagnosis:____

Name of person completing this form and relationship to child:_________________
____

Who referred you to our facility?_____________________________________
Child's Primary Care Physician:______________________________________

Birth History

Any problems during pregnancy?_____________________________________
Any problems during delivery?______________________________________
Was child premature?____
Was labor induced?____________ Birth Weight ______________

At what age did your child do the following?
Made sounds (coo, babble) _____ Sat alone ______ Crawled _____
Walked alone_____

Is your child:

Toilet trained ___ yes ___no
Bottle weaned ___ yes ___no
Pacifier weaned ___ yes ___no

Family/Social Information:

Does this child have siblings? _____Yes _____No If yes, please complete below:
Siblings:

Name	Age	Sex	Grade
________________	____	____	_____
________________	____	____	_____
________________	____	____	_____
________________	____	____	_____

Who does this child live with?____

Does this child attend school/daycare (where?)__________________________________

Please describe your child's typical behavior at home and in the community:
____
____