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Pediatric OT Developmental History Questionnaire

Child's Name _____ Birthdate _____

Prenatal and Birth History:

Any complications during pregnancy or birth? Any medical interventions? Please describe.

Medical History:

Has your child had any significant illnesses or injuries? Please describe. _____

	Yes	No
Has your child had frequent ear infections?	_____	_____
Does your child respond consistently to sound?	_____	_____
Has your child's vision been tested?	_____	_____
If yes, please note results _____		
Does your child have allergies?	_____	_____
If yes, please note what he/she is allergic to _____		
Has your child had any seizures or periods of unconsciousness?	_____	_____
If yes, please add details _____		
Any current medications?	_____	_____
If yes, please note medication and purpose _____		
Pediatrician and phone number: _____		

Motor Development

Age sat unsupported _____ Age fed self _____ Age pedaled trike _____
 Age crawled _____ Age dressed self _____ Age rode bike _____
 Age walked _____ Age toilet trained _____ Age tied shoes _____
 Does your child seem clumsy or poorly coordinated? _____

Poor suck in infancy? _____ Drooling after 2 ½ years? _____ Difficulty chewing? _____
 Any current problems with self-care? _____
 Does your child independently manage buttons? _____ snaps? _____ zippers? _____
 Does your child hold eating utensils appropriately for his/her age? _____
 Cut food independently with a table knife? _____ Hold a pencil appropriately? _____
Handedness: Hand used for writing? _____ Drawing? _____ Brushing teeth? _____
 Eating with a fork? _____ Cutting with scissors? _____ Throwing a ball? _____
 Age at which hand preference was consistent? _____
 Additional comments about motor development? _____

Language Development

Age spoke first word _____ Age put 2-3 words together _____ Articulation ok? _____
Additional comments about speech/language development? _____

Behavioral Characteristics

Does your child get along well with other children? _____
Does your child get along well with adults? _____

Is your child ...?	Yes	No	Comments
Shy?	_____	_____	_____
More active than others?	_____	_____	_____
Impulsive	_____	_____	_____
Wiggly when seated	_____	_____	_____
Easily distracted	_____	_____	_____
Socially engaged	_____	_____	_____
Interested in learning	_____	_____	_____
Does your child ...?			
Have difficulty sleeping	_____	_____	_____
Have a limited food repertoire	_____	_____	_____
Avoid certain food textures	_____	_____	_____
Suck his/her thumb	_____	_____	_____
Chew on non-food objects	_____	_____	_____
Avoid some clothing textures	_____	_____	_____
Avoid getting hands messy	_____	_____	_____
Touch objects/people frequently	_____	_____	_____
Easily become dizzy or carsick	_____	_____	_____
Enjoy fast-moving rides	_____	_____	_____
Object to certain sounds	_____	_____	_____
Object to bright lights	_____	_____	_____

Please add any other behavioral characteristics or observations _____

What are your child's favorite activities? _____

What things does your child tend to fear or avoid? _____

Educational History

Has your child attended preschool? If so, please note which school, dates of attendance, and any concerns raised by the school. _____

Has your child attended kindergarten? If so please note which school, dates of attendance, and any concerns raised by the school. _____

Please note elementary school(s) attended, and any concerns raised by the school(s). _____

Does your child like school? _____

Does your child have an IEP? Any special services provided at school? _____

Has the school recommended any private services for your child? _____

Has your child participated in any evaluations outside of school, with private therapists or agencies? If yes, please summarize the results, and note dates services were provided and by whom. _____

Has your child participated in tutoring or therapy services outside of school, with private tutors/therapists or private agencies? If so, please note services provided, when, and by whom. _____

General

Is English the only language spoken at home? If not, what other language(s) are used? _____

Do any family members have a history of learning differences, speech/language difficulties, coordination difficulties, or emotional difficulties? If so, please describe. _____

Please add any other comments that may be relevant for planning your child's evaluation or therapy. _____

Parent Signature _____ Date _____