PlaySteps for Developing Kids LLC
...let's play for a change

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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 _____