OC Therapy Group
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Child Developmental History Record

A. Identifications

1. Child's name: ____ Birth Date: ______________Age: ______

Person(s) completing this form: _______________________________ Relationship: ____________________

Today's date: ______________

2. Mother's name: _______________________________ Birth Date: ____________

3. Father's name: _______________________________ Birth date: _____________

4. Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married

❑ Other: ______________________

Child's custodian/guardian is: ____

5. Stepparent's name: ___________________________________ Birth date: __________

Home phone:_____________ Address: ____

Currently employed: ❑ No ❑ Yes, as: ___________________________________

Work phone: ____________________

6. Other adult family members?

____

____

B. Development

Please fill in any information you have on the areas listed below.

1. Pregnancy and delivery

Prenatal medical illnesses and health care:

____

____

____

Was the child premature? ❑ No ❑ Yes.

Weight and height at birth: ______________ pounds _____________ inches

Any birth complications or problems? ____

____

Was the pregnancy planned or a surprise: ____

2. The first few months of life

Breast-fed? If so, for how long? Any allergies? _______________________________________

____

____

Sleep patterns or problems: ____

____

____

3. Milestones: At what age did this child do each of these?

Sat without support: ________________ Crawled: __________________

Walked without holding on: _______________ Helped when being dressed: __________

Tied shoelaces: ____________ Buttoned buttons: _______________

Ate with a fork: _______________ Stayed dry all day: ___________ Didn't soil his or her pants: ____________

Stayed dry all night: _____________

4. Speech/language development

Age when child said first word understandable to a stranger: ______________

Age when child said first sentence understandable to a stranger: _____________

Any speech, hearing, or language difficulties? ____

____

C. Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

D. Residences

1. Homes

Dates					
From	To	Location	With whom	Reason for moving	Any problems?

2. Residential placements, institutional placements, or foster care

Dates				
From	to	Program name or location	Reason for placement	Problems?

E. Schools

School (name, district, address, phone) Grade Age Teacher

May I call and discuss your child with the current teacher? ❑ Yes ❑ No

Name and contact information: ____

F. Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.: _____________________________

____

____

G. Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?____

____