AZ PT KIDS PLACE
Play better. Function better. Live better.

DEVELOPMENTAL HISTORY

Child's Name: ____

Date of Birth: ______________________

Reason for Referral: ____

Diagnoses: ____

Parent/Caregiver Primary Concern ________________________________
____

BIRTH HISTORY

Child born premature?: Yes ___ No ____ If Yes, born at what week: ______________

Delivery:

____ Spontaneous ____ Breech ____ Cord around neck
____ induced? ____ Normal ____ Hemorrhage
____ Cesarean ____ Infant injured during delivery
Explain:_________________________________
____ Positive for substances?
Specify:_________________________________

Birth:

Weight ___________ Length ___________

Post Delivery Period:

____ Jaundice ____ Cyanosis (turned blue)
____ Intensive Care ____ Infection: ___________________________
____ Cerebral Bleed ____ Other complications: ___________________
____

Days in hospital after delivery for Child: _____________________

EARLY DEVELOPMENT

Milestones:

Sitting Unsupported: ___________________________

Crawling: ___________________________

Walking: ___________________________

First word:___________________________

Toilet trained: ___________________________

Dress self: ___________________________

Please list all relevant surgeries ____________________________________
____
____

MISCELLANEOUS

Previous Therapies (please circle all that apply): OT / PT / Speech

Clinic: ____

School: ____

Does your child have an IEP? ____ 504 Plan? ____

What therapies does your child receive in school? ______________________________