



5. Other Family Members out side of the home:

Name	Relationship	Birth year	Residence

6. Family Changes:

Has your child moved? \_\_\_\_ How many times? \_\_\_\_ No. of School Changes \_\_\_\_ Retention \_\_\_\_\_

Death of a close relative? \_\_\_\_\_ Extended illness of close family member? \_\_\_\_\_

Lived with someone besides parent? \_\_\_\_\_ Parents separated/divorced? \_\_\_\_\_

Other \_\_\_\_\_

**MEDICAL/PHYSICAL HISTORY**

1. Pregnancy History: (medications, when did prenatal care begin, maternal health, drugs/alcohol/cigarettes)

2. Birth History: (full term, premie, birth weight, problems in labor/delivery, baby's health)

3. Medical Evaluations/Diagnoses/Current or Past Therapies: (dates, by whom)

Primary Physician: \_\_\_\_\_

4. Serious Illnesses/Injuries/Hospitalizations: (allergies, high fevers, asthma, seizures, unconsciousness, operations, poisoning/overdoses, ear infections, accidents)

5. Vision:  No Concerns    Screening Date: \_\_\_\_\_ Assessment Date: \_\_\_\_\_

Hearing:  No Concerns    Screening Date: \_\_\_\_\_ Assessment Date: \_\_\_\_\_

6. Family Health History: (anyone with seizures, retardation, asthma, blood disorders, diabetes, heart problems, other health concerns)

**MOTOR SKILLS:**

1. Sits without support  No  Yes When? \_\_\_\_\_

2. Age of: Rolling: \_\_\_\_\_ Crawling: \_\_\_\_\_ Cruising: \_\_\_\_\_ Walking: \_\_\_\_\_

3. Can your child jump with both feet off the ground?  No  Yes

4. Does your child fall or trip frequently?  No  Yes (Examples: \_\_\_\_\_)

5. When attempting a new motor activity (playground equipment), does your child consistently have difficulty knowing how to move his/her body or coordinate movements to complete the task?  No  Yes

6. Experience with scissors?  No  Snips  Cuts across paper

7. Experience with drawing?  No  Scribbles  Simple Shapes  Recognizable Figures  Letters \_\_\_\_\_

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**SELF-CARE/SENSORY SKILLS:**

1. Describe your child's dressing skills: \_\_\_\_\_  
\_\_\_\_\_

2. Toilet trained? \_\_\_No \_\_\_Yes Age: \_\_\_\_\_ Dry at night? \_\_\_\_\_

3. Feeding/Eating:

a. Breast/bottle feeding \_\_\_\_\_  
\_\_\_\_\_

b. Solids: Uses Utensils \_\_\_No \_\_\_Yes Open/Lidded Cup \_\_\_\_\_ Drooling: \_\_\_No \_\_\_Yes

c. Feeding Patterns, Messiness \_\_\_\_\_  
\_\_\_\_\_

d. Food Preferences: (likes/dislikes, picky?) \_\_\_\_\_  
\_\_\_\_\_

4. Routines: Describe routines/rituals you use at home (bedtime, bathing, eating, dressing)

\_\_\_\_\_

5. Sleeping: Describe your child's sleep patterns: \_\_\_\_\_  
\_\_\_\_\_

6. Sensory Concerns (Avoidant? Seeker?)

a. Tactile (wiping face, clothing textures, messy hands, walking surfaces, bang into things, hug hard, jump, roughhouse) \_\_\_\_\_  
\_\_\_\_\_

b. Auditory (startles, aversive noises, music, environmental noises, respond to name) \_\_\_\_\_  
\_\_\_\_\_

c. Visual (eye contact, spinning objects, staring at lights, etc.) \_\_\_\_\_  
\_\_\_\_\_

**BASIC SKILLS:**

1. Can your child label colors? \_\_\_\_\_ How many? \_\_\_\_\_

2. What shapes can your child label? \_\_\_\_\_

3. How far can your child rote count? \_\_\_\_\_ Rational count? \_\_\_\_\_

4. How many letters/words can your child recognize/name? \_\_\_\_\_

5. How many letters can your child write? \_\_\_\_\_

6. How many letter sounds does your child know? \_\_\_\_\_

7. How well does your child read, do math computation, written expression? \_\_\_\_\_

**SOCIAL/PLAY/INTERACTION SKILLS:**

1. What are your child's favorite things to play with (hobbies/interests)? \_\_\_\_\_

\_\_\_\_\_

2. What does the play look like? (story line, narrative?) \_\_\_\_\_

\_\_\_\_\_

3. How long does your child stay with one activity before changing? \_\_\_\_\_

4. How does your child handle transitions between activities/situations? \_\_\_\_\_

5. Does your child like to be read to (read on his/her own)? \_\_\_\_\_ How long? \_\_\_\_\_

Can he/she answer simple comprehension questions about the story? \_\_\_\_\_

6. Can your child play/spend time alone (entertain self)? \_\_\_No \_\_\_Yes How long? \_\_\_\_\_

7. Who does your child play with? (adults, older children, peers) \_\_\_\_\_

8. How does your child respond when someone tries to take a toy away from him/her? \_\_\_\_\_

9. How does your child initiate/respond/interact with others (peers, adults)? \_\_\_\_\_

\_\_\_\_\_

With less familiar people/situations? \_\_\_\_\_

10. What opportunities does your child have to interact with others in the community? \_\_\_\_\_

\_\_\_\_\_

**BEHAVIOR:**

1. What do you like best about your child? \_\_\_\_\_

2. How do you think your child feels about him/herself? \_\_\_\_\_

3. How does your child manage frustration (when doesn't get what he/she wants?) \_\_\_\_\_

4. How does your child solve a problem/overcome an obstacle? \_\_\_\_\_

5. How does your child let you know he/she needs help? \_\_\_\_\_

Can he/she get help from other people? \_\_\_\_\_

6. Do you have major behavior concerns about your child (tantrums, safety concerns)? \_\_\_\_\_

\_\_\_\_\_

7. How do you handle your child's behavior? How well does it work? \_\_\_\_\_

\_\_\_\_\_

8. What is a good reward for your child? \_\_\_\_\_

**COMMUNICATION SKILLS:**

1. What sounds is your child producing? \_\_\_\_\_

2. Does your child imitate sounds/actions \_\_\_\_\_

3. What kinds of gesture games does your child play? (peek-a-boo, patty cake) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. How does he/she indicate needs/wants?

Gesture/Sign \_\_\_\_\_

Word Approximations \_\_\_\_\_

Words \_\_\_\_\_

Word Combinations \_\_\_\_\_

Other Nonverbal Systems (PECS, voice output) \_\_\_\_\_

5. Does your child point to objects/pictures when named? \_\_\_\_\_

6. At what age did your child start using single words? \_\_\_\_\_ How many words? \_\_\_\_\_

7. How many words does your child put together in a sentence? \_\_\_\_\_

8. Is your child's speech hard to understand? (interpret for others?) \_\_\_\_\_

9. What kinds of directions does the child follow? (with gestures/cues? \_\_\_\_\_ No \_\_\_\_\_ Yes

One step \_\_\_\_\_

Two/plus steps \_\_\_\_\_

10. What kinds of questions does the child understand? (what, what doing, who, where, when, why, how?)

11. What kinds of questions does the child ask? Does/he she seem to understand the answer? \_\_\_\_\_

\_\_\_\_\_

12. What bothers you most about your child's communication skills? \_\_\_\_\_