

## DEVELOPMENTAL HISTORY FORM - SUMMER

This form will help us prepare for the child's consultation and needs at our program.

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### **Developmental Milestones - Motor, Speech, Language, Communication:**

<i>Please rate the following areas:</i>	<u>Normal</u>	<u>Adequate</u>	<u>Concern</u>	<u>Poor</u>
Gross Motor Skills	1	2	3	4
Fine Motor Skills	1	2	3	4
First word at 12 mos. <i>First word was:</i>	1	2	3	4
2 word combination at 24 mos.	1	2	3	4
3 word combination at 3yrs.	1	2	3	4
Articulation	1	2	3	4
Cohesion in conversation	1	2	3	4
Conversation with others on topics of mutual interest	1	2	3	4
Inflection	Normal	Flat	Monotone	Pedantic

### **Does (or did) your child's quality of language or conversational content include:**

- Idiosyncratic use of words       Yes    No  
Repetitive patterns of speech    Yes    No  
Echolalia                               Yes    No

### **Non-verbal / Non-literal Communication:**

<i>Please rate the following abilities:</i>	<u>Normal</u>	<u>Adequate</u>	<u>Concern</u>	<u>Poor</u>
Interpreting facial expressions:	1	2	3	4
Using facial expressions:	1	2	3	4
Making eye-contact	1	2	3	4
Giving messages with eyes	1	2	3	4
Using hand gestures	1	2	3	4
Cognizant of body in space	1	2	3	4
Maintains proper distance from others	1	2	3	4
Responding to nonverbal cues in conversation	1	2	3	4

Do you suspect your child could read facial expressions and use body language if prompted, or do you feel he or she has a deficit in this ability? \_\_\_\_\_

Does your child understand:

Non-literal speech:  Yes  No                      Joking:  Yes  No  
Irony:  Yes  No                                      Metaphors:  Yes  No  
Sarcasm:  Yes  No                                    Intent of communication:  Yes  No

Emotions: Please rate the following at they relate to emotions.

Understanding of emotions:  Full Range  Only knows Sad, Happy, Angry  Difficulty with understanding  
Changes In affect:  Smooth  Fixed  Abrupt  Other: \_\_\_\_\_

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Did (or does) your child have difficulty understanding the feelings of others?  Yes  No

**Cognitive Functioning:**

<u>Does (or is) your child:</u>	<u>Yes</u>	<u>No</u>
Good at details:	<input type="checkbox"/>	<input type="checkbox"/>
See the whole picture:	<input type="checkbox"/>	<input type="checkbox"/>
Understand cause and effect relationship:	<input type="checkbox"/>	<input type="checkbox"/>
Able to generate alternative solutions to problems:	<input type="checkbox"/>	<input type="checkbox"/>

**Social Functioning:**

Does your child feels anxious in situations involving new people:  Yes  No  
Is your child preoccupied with inner world or “out of touch:  Yes  No

<u>Check all that apply:</u>	<u>Yes</u>	<u>No</u>
Have close friends:	<input type="checkbox"/>	<input type="checkbox"/>
Avoid others:	<input type="checkbox"/>	<input type="checkbox"/>
Have interest in friends:	<input type="checkbox"/>	<input type="checkbox"/>
Greet other in an appropriate manner:	<input type="checkbox"/>	<input type="checkbox"/>
Read cues to enter group:	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty or clumsy approach to group:	<input type="checkbox"/>	<input type="checkbox"/>
Have exit skills:	<input type="checkbox"/>	<input type="checkbox"/>
Usually shares and takes turns willingly	<input type="checkbox"/>	<input type="checkbox"/>
Usually plays well with two or more children	<input type="checkbox"/>	<input type="checkbox"/>
Willingly and cooperatively participates in a small group, activity or game?	<input type="checkbox"/>	<input type="checkbox"/>
Has one sided response to conversations	<input type="checkbox"/>	<input type="checkbox"/>
Has a one-sided response to peers	<input type="checkbox"/>	<input type="checkbox"/>

Interests:

Is your child's range of interests:

- Limited (no interests)
- Restricted to 1 interest (child seems obsessed by one area of interest)
- Restricted to 1 or 2 interests
- Typical
- Other:

Please describe your child's interests:

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Sensory integration:

Did or does your child have sensory integration difficulties (difficulty with sensory system modulation)?

- Yes  No Explain:

Self-stimulation Behaviors:

Does (or did) your child engage in self stimulating behaviors (eg., flapping, rocking sitting, etc.)?

- Yes  No Explain:

Need for Sameness:

**Did (or does)** your child have:

- Yes  No Difficulties in transitions
- Yes  No Difficulty with small, non-functional changes in routines or details