TreehouseSpeech.net

**Treehouse Speech and Rehabilitation**

**Ellwood City** 26 Pittsburgh Circle, Ellwood City PA 16117 • phone 724.752.1551 • fax 724.752.8573
**Grove City** 120A South Broad Street, Grove City, PA 16127 • phone 724-458-1500 • fax 724-458-1501
**New Castle** 2656 Wilmington Road, New Castle, PA 16105 • phone 724-752-1551 • fax 724-752-8573

# DEVELOPMENTAL QUESTIONNAIRE

Child's Name:_____ DOB:_____ Today's Date:_____

Address:_____ Emergency Contact:_____

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Step-parent ☐ Guardian

Is child your: ☐ Biological Child ☐ Adopted Child ☐ Foster Child ☐ Other:_____

Marital Status of Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Single Parent

Biological Father:_____ Biological Mother:_____

Step-parent:_____ Legal Guardian:_____

If the child lives with one parent, does he/she visit with the non-custodial parent? ☐Yes ☐ No If so, how often?_____

What changes have there been in your family?_____

What other adults have an important role in raising your child?_____

| Others in the home: | Name | Age | Relationship | Name | Age | Relationship |
|---|---|---|---|---|---|---|
| | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |

Is English a Second Language for him/her? ☐ Yes ☐ No Language(s) spoken in the home: _____

## EDUCATION / INTERVENTION HISTORY:

Does your child attend: ☐ Daycare_____ ☐ Preschool _____ ☐ School Age / Current Grade _____

Has your child previously been evaluated? ☐Yes ☐ No If Yes, by whom and when:_____

If yes, what was found? _____

Has your child ever received occupational, physical or speech/language therapy? If so, by whom and when:_____

_____

## PREGNANCY AND BIRTH HISTORY:

Mother's age at birth:_____ Did mother receive routine medical prenatal care: ☐ Yes ☐ No

Did child go home from hospital at the same time as the mother? ☐ Yes ☐ No
If no, explain why:_____

**Pregnancy**
- ☐ Normal
- ☐ Falls
- ☐ Excessive Bleeding
- ☐ Blackouts
- ☐ Perinatal Infections: Toxoplasmosis Herpes, cytomegalovirus, rubella
- ☐ Emotional Stress
- ☐ Lack of Prenatal Care
- ☐ Alcohol/Drug Use
- ☐ Use of Tobacco

**Delivery**
- ☐ Natural
- ☐ Induced
- ☐ Caesarean
- ☐ Breech
- ☐ Unusually Long Labor
- ☐ Premature (# weeks_____)
- ☐ Birth weight_____
- ☐ Overdue (# weeks_____)
- ☐ Other:_____

**Condition at Birth**
- ☐ Normal
- ☐ Severe Jaundice, hyperbilirubinemia, kernicterus, or premature liver requiring blood transfusions
- ☐ Breathing Problems
- ☐ Difficulty sucking or feeding
- ☐ Birth defects/Injury
- ☐ Difficulty gaining weight
- ☐ Newborn ICU stay (# Days _____)

## CHILD'S HEALTH HISTORY:

When was your child's last physical? _____ Child's state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has your child been treated for serious medical or psychological conditions? Please and provide diagnosis: _____

_____

What medication(s) is your child currently taking? Include dosages:_____

Please check if your child had any of the following: *(If so, please describe)*

☐ Head Injuries, Seizures or convulsions:_____
☐ Surgery/Hospitalizations:_____
☐ History of Ear Infections:_____
☐ Allergies and/or Asthma:_____
☐ Vision Problems:_____
☐ Hearing Problems:_____

## FAMILY HEALTH HISTORY: (*Please check off whether any family members have a history of any of the following conditions. If yes, please note the child's relation to the family member with the condition in the space provided.)*

☐ Attention Deficit/Hyperactivity _____
☐ Depression _____
☐ Anxiety _____
☐ Bipolar Disorder _____
☐ Substance Abuse/Dependency _____
☐ Autism/Asperger/Pervasive Developmental Disorders_____
☐ Learning Problems or Learning Disabilities _____
☐ Developmental Delays _____
☐ Neurological disease _____
☐ Seizures _____
☐ Hearing problems _____
☐ Visual Problems _____
☐ Speech/Language Problems_____
☐ Intellectual Disability _____
☐ Other _____

## DEVELOPMENTAL HISTORY:

During your child's first *few years of life*, was any of the following present to *significant* degree?

☐ Did not enjoy cuddling
☐ Was not easily calmed by being held or stroked
☐ Difficult to comfort
☐ Colicky
☐ Excessive irritability
☐ Diminished sleep
☐ Difficult nursing
☐ Poor eye contact/did not turn towards caregivers
☐ Did not respond to name or speech of caregivers
☐ Fascination with certain objects
☐ Constantly into everything
☐ Frequent head banging

*If checked any above, please describe:_____

_____

**Milestones:** *(Please note the age the following were achieved. If unsure of the age, check whether it was achieved early, late or within normal limits)*

| | Age | Early | Normal | Late | | Age | Early | Normal | Late |
|---|---|---|---|---|---|---|---|---|---|
| Rolled over | _____ | ☐ | ☐ | ☐ | Buttons/Zips | _____ | ☐ | ☐ | ☐ |
| Sat without support | _____ | ☐ | ☐ | ☐ | Tied shoes | _____ | ☐ | ☐ | ☐ |
| Crawled | _____ | ☐ | ☐ | ☐ | Pedaled tricycle | _____ | ☐ | ☐ | ☐ |
| Stood up | _____ | ☐ | ☐ | ☐ | Rode bike | _____ | ☐ | ☐ | ☐ |
| Walked alone | _____ | ☐ | ☐ | ☐ | Grasped pencil/crayon | _____ | ☐ | ☐ | ☐ |
| Fed self | _____ | ☐ | ☐ | ☐ | Babbled | _____ | ☐ | ☐ | ☐ |
| Dressed self | _____ | ☐ | ☐ | ☐ | Spoke first words | _____ | ☐ | ☐ | ☐ |
| Brushes Teeth | _____ | ☐ | ☐ | ☐ | Spoke in short sentences | _____ | ☐ | ☐ | ☐ |

## SENSORIMOTOR DEVELOPMENT *(Please check off the following items that relate to your child's sensory and motor skills)*

**TACTILE (TOUCH):**
- ☐ Tends not to feel pain
- ☐ Touches/feels objects frequency
- ☐ Has trouble managing personal/physical space
- ☐ Over sensitive to clothing/textures
- ☐ Under sensitive to clothing/textures/foods
- ☐ Avoids getting hands messy
- ☐ Dislikes having haircut/face washed
- ☐ Bumps into furniture, people often

**VISUAL**
- ☐ Has trouble tracking objects with eyes
- ☐ Avoids eye contact with others
- ☐ Has trouble copying words from the board
- ☐ Has trouble putting puzzles together

**TASTE & SMELL**
- ☐ Picky eater
- ☐ Has trouble eating different textured foods
- ☐ Has trouble chewing/swallowing
- ☐ Sensitive to smells/tastes
- ☐ Prefers certain textures
- ☐ Chews or licks non-food objects

**AUDITORY (SOUND)**
- ☐ Sensitive to loud sounds (school bells, sirens)
- ☐ Fails to listen, or pay attention to what is said to him/her
- ☐ Is distracted if there is a lot of noise

**MOVEMENT & COORDINATION**
- ☐ Loses balance easily
- ☐ Likes rough housing, jumping, crashing games
- ☐ Gets carsick easily
- ☐ Prefers to be sedentary (on computer/ TV) rather than play outside?
- ☐ Seems generally weak compared to other kids
- ☐ Has difficulty playing on playground equipment
- ☐ Poor ball skills: catching, kicking, throwing
- ☐ Seems clumsy, awkward
- ☐ Mixed hand preference/Ambidextrous
- ☐ Has difficulty cutting with scissors
- ☐ Has difficulty holding a pencil or crayon in a 3-point position
- ☐ Has trouble using both hands together easily (opening milk carton, water bottle etc.)
- ☐ Drops items frequently
- ☐ Has trouble picking up/manipulating small items
- ☐ Has difficulty writing/drawing

## SOCIAL HISTORY:

List some of your child's favorite toys, activities & hobbies:_____

_____

Does your child have friends his/her own age? ☐ Yes ☐ No (If No, are friends usually Younger ☐ Older ☐)

How does the child get along with brothers/sisters/other children their age? _____

Describe child's social activities, clubs, and other opportunities (church involvement, team sports, clubs, other groups);

_____

Check any of the following characteristics that describe your child:

| | | | |
|---|---|---|---|
| ☐ Happy | ☐ Low Self Esteem | ☐ Distractible | ☐ Aggressive |
| ☐ Sensitive /Cries Easily | ☐ Teases Others | ☐ Argumentative /Argues | ☐ Friendly |
| ☐ Tantrums | ☐ Shy | ☐ Daydreams | ☐ Quiet |
| ☐ Athletic | ☐ Fearful | ☐ Depressed | ☐ Easy to Please |
| ☐ Overactive | ☐ Clumsy | ☐ Artistic | ☐ Difficult |
| ☐ Fights | ☐ Moody | ☐ Social | ☐ Other: |

What responsibilities does your child have at home? _____

What time does your child go to bed? _____ Does he/she sleep well? ☐ Yes ☐ No What time does your child wake up?_____

What are your child's strengths? _____

What are your concerns about your child? _____

What specific goals would you like your child to achieve through therapy? _____

_____

How did you hear about us? (Please include name if referred by a person)? ☐ Internet ☐ Doctor _____

☐ Friend _____ ☐ School-based or other therapist_____ ☐ Other _____

How do you prefer we contact you? ☐ Phone:_____ ☐ Text:_____ ☐ E-Mail:_____

Form Completed By:_____