Cardinal Hill Rehabilitation Hospital
Center for Outpatient Services
Pediatric Developmental History

Client Information Label

Date: _____

Nickname: _____ Sex: ☐ M ☐ F Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Person Completing Form: _____ _____

Relationship to Child: _____Referred By: _____ Reason for Referral: _____

In case of an emergency, which hospital do you prefer? _____

Medical History

Please list your child's primary care doctor and other specialists who care for your child:

Doctor	Address	Reason Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that apply:

☐ Lung and Breathing Problems	☐ Hearing Difficulties/Loss	☐ Spina Bifida	☐ Developmental Delay
☐ Heart Problems	☐ Spinal Cord Injury	☐ Orthopedic Injuries	☐ Sensory Integration
☐ Anoxia	☐ Down Syndrome	☐ Autism/PDD	☐ Attention Deficit Disorder
☐ Seizures	☐ Vision Difficulties	☐ Ear Infections	☐ Mumps
☐ Closed Head Injury	☐ Meningitis	☐ Learning Disabilities	☐ Chicken Pox
☐ Stroke	☐ Cerebral Palsy	☐ Measles	☐ Other _____

ALLERGIES

Please list anything that your child is allergic to and their reaction. Please be specific.

☐ Food Allergies: _____

☐ Medications: _____

☐ Other: _____

Please indicate any of the following that your child may have experienced:

☐ Major Illnesses/Surgeries: _____

_____

☐ Hospitalizations: _____

☐ Accidents: _____

Medications/Supplements

Name	Dosage	Frequency Taken	Side Effects	Prescribing M.D.

Pregnancy/Birth History

Pregnancy was normal: ☐ Yes ☐ No Birth was normal: ☐ Yes ☐ No Adopted? ☐ Yes ☐ No

Please check all that apply:

☐ Vaginal Delivery ☐ Cesarean ☐ Use of Forceps ☐ Breech ☐ Baby Rotated

☐ Cord around neck ☐ Transfusion Required ☐ Premature If yes: Number of Weeks _____

Child's Weight at Birth: ____ lbs. _____ oz. Apgar Score: _____ Length of Labor: _____

Length of child's stay in the hospital: _____

List any treatments needed from birth to present (oxygen, incubator) _____ For how long? _____

Multiple Birth: ☐ Yes ☐ No If yes: ☐ Twin ☐ Triplet ☐ Other: _____

Siblings: ☐ Yes ☐ No If yes, child is: ☐ 1st born ☐ 2nd born ☐ Other: _____

Client Information Label

Family History

Parents' Name(s): Mother _____ Father: _____

Legal Guardian: _____Other persons living in the home: _____

Relationship to child: _____

Is there a history of the following in your family? If yes, please explain on the lines provided.

Hearing Problems: ☐Yes ☐No _____

Speech Problems: ☐Yes ☐No _____

Vision Problems: ☐Yes ☐No _____

School Difficulties: ☐Yes ☐No _____

Heart Disease: ☐Yes ☐No _____

Lung Disease: ☐Yes ☐No _____

Diabetes: ☐Yes ☐No _____

Developmental History

Physical Skills: At what age did your child first do the following?

Roll: _____ Sit: _____ Stand: _____ Walk: _____ Climb Stairs: _____

Describe any problems/concerns: (coordination, balance, falls, etc.) _____

Communication: (Is this related to the reason your child is being seen today? ☐Yes ☐ No)

At what age did your child first do the following?

Babble: _____ Make nonsense words: _____ Respond to his/her name: _____Gesture or point: _____Sign: _____

Attempt to imitate speech: _____ Use single words: _____Use two word sentences: _____

Did your child start talking and then stop? ☐Yes ☐No If yes, when? _____

My child's voice is: ☐Normal ☐Hoarse ☐Nasal ☐High Pitched ☐Low Pitched ☐Loud ☐Quiet ☐Other: _____

Check any that describe your child:

☐Uses the wrong words ☐ Can't follow directions ☐Doesn't ask questions ☐Uses only gestures to communicate

☐Repeats certain sounds/words over and over ☐Can't get the words out ☐Starts/stops/starts speech again

☐Talks too fast ☐Talks too slowly ☐Talks too softly ☐Talks too loudly ☐Can't relay information

☐Gets stuck on certain sounds/words

Child is understandable to: ☐Parents ☐Siblings ☐Grandparents ☐Other Children ☐Teachers ☐Strangers

Child talks to other children his/her age: ☐Yes ☐No

Describe any other problems/concerns: _____

_____

Feeding: (Is this related to the reason your child is being seen today? ☐Yes ☐No)

At what age did your child do the following?

Wean from the bottle: _____Finger Feed: _____ Take Solid Food: _____ Use a spoon/fork: _____

Drink from a cup: _____Use a Straw: _____

Describe any problems/concerns: _____

_____

Self Care: (Is this related to the reason your child is being seen today? ☐Yes ☐No)

At what age did your child do the following?

Wash Hands: _____ Undress: _____ Dress: _____ Button: _____ Brush Teeth: _____

Comb Hair: _____Tie Shoes: _____ Become bladder trained: _____Become bowel trained: _____

Describe any problems or concerns: _____

Hearing: (Is this related to the reason your child is being seen today? ☐Yes ☐No)

Check any that describe your child:

☐Hearing seems to change from week to week ☐Doesn't understand verbal requests ☐Ignores Sounds

☐Can't locate source of sound ☐Hears better with one ear than the other

My child complains of: ☐Dizziness ☐Ringing /Noise in ears ☐Loud sounds

My child has a diagnosed hearing loss: ☐Yes ☐No If yes, when was it first diagnosed? _____ By whom: _____

My child wears a hearing aid: ☐Yes ☐No If yes, child wears aid in: ☐Right Ear ☐Left Ear Type: ☐Body ☐Ear Level ☐Bone

Client Information Label

Vision: (Is this related to the reason your child is being seen today? ☐Yes ☐No)
My child's last eye exam was: _____My child wears ☐Glasses ☐Contact Lens ☐Other: _____
My child has a vision related diagnosis: ☐Strabismus ☐Amblyopia ☐Low Vision ☐Other: _____
Does your child complain of Headaches? ☐Yes ☐No or Eye Strain when reading or doing close up work? ☐Yes ☐No
Does your child frequently lose his/her place when reading? ☐Yes ☐No

Social Skills

Does your child separate easily from parents? ☐Yes ☐No If no, please explain: _____
Does your child play alone? ☐Yes ☐No For how long at a time? _____
Does your child play with other children? ☐Yes ☐No Doing what, and for how long at a time? _____
_____
What are your child's favorite toys and/ or play activities:_____

Behavior/Discipline

Check any that describe your child:
☐Overactive ☐Aggressive ☐Fearful ☐Difficult to Discipline ☐Destructive ☐Withdrawn ☐Restless
☐Poor Self Esteem ☐Happy ☐Unhappy ☐Temper Tantrums ☐Cries Easily ☐Outgoing ☐No Fears ☐Shy
Does your child have any unusual behaviors or concerns? _____
What is the most effective way to discipline your child? _____
What do you do to reinforce your child for doing something good? _____

Previous Therapy, Educational Services, or Alternative Medicine

Please list educational and/or therapy services that your child has received in the past and/or is currently receiving. (Includes developmental intervention, preschool, childcare centers, school, resource teachers, tutoring, etc.)

School/Agency Name	Type of Therapy	Teacher's Name	Approximate Dates

Has your child experienced any difficulties in the above settings? ☐Yes ☐No If yes, please explain: _____
_____

Other

Does your child have any sensory strategies or equipment to help him/her throughout the day? ☐Yes ☐No

Type of equipment or sensory strategy used	Vendor (if applicable)

Does your child have a history of emotional, physical, or sexual abuse? ☐Yes ☐No If yes, please explain: _____
_____
Is there any other information that would be helpful to us in working with your child? _____
_____

Discharge Plan

What goals would you like to have accomplished at the time of discharge for the following:
Speech/Language: _____
Occupational Therapy: _____
Physical Therapy: _____
Developmental Intervention: _____
Hearing: _____
Other: _____
Parent/Caregiver Signature: _____ Date: _____
Team Members Signature(s)/Initials:
_____ _____ Date: _____
_____ _____ Date: _____
_____ _____ Date: _____