Developmental History:

Client's Name: _____ Date of Birth: _____

Significant Birth/Medical History: _____

_____

_____

Age Child Achieved Developmental Milestones: (Complete if applicable)

Rolling: _____ Crawling: _____

Sitting Independently: _____ Walking: _____

Finger Feeding: _____ Spoon/Fork Use: _____

Babbling: _____ Gesture Use: _____

Talking: 2-3 words: _____

Please identify atypical patterns of development or skills that concern you as a parent/guardian:

_____

_____

_____

_____

Does your child have a history of aggressive behaviors to self or to others? If yes, please explain.

_____

_____

Please identify any therapeutic services your child is currently receiving or has received in the past:

Speech Therapy: _____ Place of Service: _____
Current: _____ Past: _____

Physical Therapy: _____ Place of Service: _____
Current: _____ Past: _____

Occupational Therapy: _____ Place of Service: _____
Current: _____ Past: _____