STONES WORTH STEPPING, P.C.

PEDIATRIC PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY

DEVELOPMENTAL CHECKLIST

Patient Name: _____

With whom does the child spend the most of his or her time?_____
_____
_____

Brothers and Sisters (include names and ages):_____
_____
_____

Prenatal/Birth History

1. Was the pregnancy full term? Yes☐ No☐
   If premature, please specify # of weeks: _____

2. Delivery Method: Vaginal☐ Cesarean☐ Breech☐ Twins☐
   (circle all that apply)

3. Were there any birth complications? _____
   Forceps? _____ Vacuum extraction? _____
   Any medical assistance required for mother or baby? _____
   _____
   _____

4. Did the baby sustain any of the following after birth?
   Seizures_____
   Colic_____
   Feeding difficulties_____
   Jaundice_____
   Cyanosis (blue baby)_____
   Other_____

Medical History

1. Does the child have a medical diagnosis? Yes☐ No☐
   _____

2. Food allergies_____
   Dietary restrictions_____
   Other allergies_____
   Vision impairment_____Glasses: Yes☐ No☐
   Hearing impairment_____Hearing aid: Yes☐ No☐
   Tubes in ears: Yes☐ No☐
   Tonsils/Adeniods removed: Yes☐ No☐ If yes, when? _____
   Bowl/Bladder difficulties: Yes☐ No☐_____

3. Surgery(s)_____
_____
_____

4. Current medication(s) and reason (s) for taking:
_____
_____
_____
_____

5. Other medical concerns: _____
_____
_____
_____

Developmental History

Milestone	Age Appropriate	Age Your Child Completed the Skill
Held Head Up Lying on Stomach	3 months	_____
Rolled Over	6 months	_____
Babbled	6 months	_____
Crawled	9 months	_____
Walked	12 months	_____
Spoke Single Words	12 months	_____
Drew with a Crayon	18 months	_____
Threw Ball While Standing	18 months	_____
Jumped	2 years	_____
Kicked a Ball	2 years	_____
Walked up Steps	2 1/2 years	_____
Spoke in Sentences	2 1/2 years	_____
Cut with Scissors	2 1/2 years	_____
Toilet Trained	3 years	_____
Rode a Tricycle	3 years	_____
Self Fed w/ Utensils	3 1/2 years	_____
Dressed/Undressed Self	4 years	_____
Rode a Bicycle	4 1/2 years	_____
Tied Shoes	5 years	_____

Does your child do the following:

1. Identify pictures in books	YES ☐	NO ☐
2. Engage in conversations	YES ☐	NO ☐
3. Follow simple 1-step directions	YES ☐	NO ☐
4. Follow multi-step directions	YES ☐	NO ☐
5. Engage in echolailia	YES ☐	NO ☐
6. Express emotion appropriately	YES ☐	NO ☐
7. Engage in creative play	YES ☐	NO ☐
8. Express difficulty feeding	YES ☐	NO ☐
9. Express difficulty sleeping	YES ☐	NO ☐
10. Makes friends easily	YES ☐	NO ☐

Hand dominance: Right ☐ Left ☐ Not established ☐

2. Do you have any concerns about your child's strength or coordination? Yes ☐ No ☐

_____
_____
_____

3. Does your child use any special equipment (wheelchair, braces, etc.)? Yes ☐ No ☐

_____
_____
_____

4. Please indicate any safety concerns your child may have:
   a. self-abusive Yes ☐ No ☐
   b. abusive toward others Yes ☐ No ☐
   c. run from building premises Yes ☐ No ☐
   d. other: _____
   _____

Education History

School:_____Grade: _____
Teacher(s):_____

1. Please list any services that your child is (a) currently receiving or (b)has received in the past. Please include dates of service. (i.e. physical therapy, occupational therapy, speech therapy, early intervention, school services, etc.)

__(a)_____
_____
_____
__(b)_____
_____

2. How is the child is doing academically (or pre-academically)? _____
_____
_____
_____
_____
_____

3. If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe some of the goals. _____
_____
_____
_____
_____

4.Have any other specialists (physicians, allergists, audiologists, psychologists, psychiatrists, chiropractors, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

_____
_____
_____
_____
_____
_____
_____

5.What are your main concerns for your child? Please list any goals for treatment you would like addressed?_____
_____
_____
_____
_____
_____
_____
_____

Signature /s/_____ Date_____

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