Play2Grow
Developmental Therapy Services

8050 SW Warm Springs Street Suite 130 Tualatin Oregon Phone: 506-564-0565 Fax: 503-563-5281 www.weplay2grow.com

MEDICAL AND DEVELOPMENTAL HISTORY

Child's Name: _____ Gender: _____ Age: _____Date of Birth: _____

I am interested in the following services:

□ Psychology □ Occupational Therapy □ Speech Therapy □ Play2Grow Behavioral Therapy Autism Services

Reason for Seeking Therapy Services/ Goals:

1. Parent Contact Information:

Parent: _____ Parent: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone:_____

Email: _____ Email: _____

Employment: _____ Employment: _____

Work Phone: _____Work Phone: _____

2. Physician Information:

Primary Care Physician: _____ Address: _____

Phone: _____Fax: _____

Other Medical Providers (List names and contact information): _____

_____

_____

3. Medical Information

A. Medical Diagnoses (Please List):

Diagnosis	Physician/Psychologist	When Diagnosed

B. Medical Precautions: _____

C. Current Medications:

Medication	Frequency/Dose	Purpose

D. Special Diet: □ No □ Yes: _____

E. Medical History: Please describe and date any of the following:

Childhood Diseases and Major Illnesses: _____

Congenital Anomalies: _____

Major Accidents/Injuries: _____

Surgeries: _____

Allergies: _____

Seizures: _____

Ear Infections (Frequency): _____Tubes in Ears: _____Tubes Current: □ Yes □ No

Allergies: _____ Seizures: _____

Vision Problems/Glasses: _____Hearing Problems/Aides: _____

Current Assistive Devices: (Wheelchair, Walker, Standing Devices, Special Seating, Orthotics):_____

_____

Most Recent Physical Exam: _____Height: _____ Weight: _____

Please list any current physical concerns: _____

4. Developmental Information:

Are you an adoptive parent?

□ No

□ Yes. Please describe circumstances and note age of child at adoption: _____

_____

_____

A. Prenatal History:

Describe any complications, illnesses, infections, and/or stress during pregnancy: _____

_____

Please note any medications during pregnancy: _____

_____

History of substance abuse during pregnancy? _____

_____

Tobacco use during pregnancy? _____

_____

Bed rest during any portion of pregnancy (How long?): _____

B. Birth History:

Full-Term? □ Yes □ No, Gestational Age: _____ Birth Weight: _____

C- Section? □ No □ Yes. Circumstances: _____

Oxygen at Birth? □ No □ Yes. Please note type and how many hours/days: _____

Birth Injuries? □ No □ Yes: _____

Intensive Care? □ No □ Yes: _____

Maternal Complications at Birth: □ No □ Yes: _____

Difficulties during the first 3 postnatal months?_____

_____

C. Developmental Milestones (Yes, Try to remember!):

Milestone	**Met on Time (Age)**	**Met Late (Age)**	**Not Yet**
Rolled			
Sat Independently			
Crawled on Belly			
Crawled Hands/Knees			
Pulled to Stand			
Cruised Along Furniture			
Walked Independently			
Weaned Breast/Bottle			
Transition Solid Foods			
First Words			
Talked in Sentences			
Toilet Trained Daytime			
Toilet Trained Night Time			

D. Please describe your child's temperament, activity level and behavior:

As an infant: _____
_____
As a toddler: _____
_____
As a preschooler: _____
_____
Current: _____
_____

E. Does your child have any difficulties with sleep? **□ No □ Yes. Describe: _____**

_____

F. Please rate your opinion of your child's development (compared to others the same age in the following areas)

	Below Average	About Average	Above Average
Social			
Fine Motor			
Large Motor			
Language			
Intellectual/Academic			
Attention/Organization			
Self-Care: Dressing			
Self-Care: Bathing			
Self-Care: Toileting			
Self-Care: Eating			
Independent Play			
Play with Others			
Emotional			

For any type of development that you rated as below average, please describe current areas of concern. Be specific. _____

_____

_____

_____

_____

_____

_____

_____

_____

G. Describe your child's hobbies and interests: _____

_____

H: What do you consider to be your child's greatest strengths: _____**?**

_____

I. Describe what types of supports you provide your child to help him/her when tasks and/or behaviors are difficult? _____

_____

_____

J. Describe how you discipline your child if/when needed. Is it effective? _____

_____

_____

H. For what reasons do you discipline your child? _____

_____

E. Educational Information (Provide information for those that apply)

_____ Early Intervention Program: _____
_____ Preschool: _____
_____ School/Grade: _____
_____ Childcare: _____
_____ Special Education Services: _____

If your child currently receives early intervention of special education services please what is his/her educational diagnosis? _____

What services does your child receive through your Educational Service District and/or school system and with what frequency? _____

F. Developmental and Educational Testing (Please list any medical, developmental, or educational testing, and any mental health assessments received within the past three years):

Type of Testing	Evaluator	Date

F. Current Intervention Services (Check all that apply):

Check	Service	Provider	Frequency
	Mental Health/Counseling		
	Physical Therapy		
	Speech Therapy		
	Occupational Therapy		
	Developmental Optometry		
	Nutritional Counseling		
	Naturopathic Treatment		
	Chiropractic		
	Therapeutic Massage		
	ABA/Intensive Autism Services		
	Therapeutic Riding		
	Social Skill Group		
	Educational Tutoring		
	Respite Care		
	Other:		
	Other:		

Thank you for completing this form. Please complete additional developmental information as follows:

□ Speech Therapy? Complete supplemental communication questionnaire
□ Occupational Therapy for Feeding Concerns? Complete supplemental feeding paperwork
□ Psychology? Complete Family History and Behavior checklist
□ Autism Spectrum? Complete Communication Partners Questionnaire