Sensorimotor History Questionnaire

Welcome to Foundations for Growing! We are happy to participate in your child's developmental care. Please complete the following to assist us in getting to know your child.

Child's Name:	**Date of Birth:**
Parent/Guardian:	**Parent/Guardian:**
Occupation:	
Mailing Address:	
Email Address:	
Phone:	

Prenatal History:	**yes**	**no**
Were there any illnesses, injuries, traumatic events, and/or exposures during the infant's gestational period? (please specify):		
Was the pregnancy full term?		
If no, how many weeks early? _____ Did the infant require intensive care? _____		
Were there any requirements for oxygen supplementation or other intervention following birth? Do you know your child's APGAR scores? If yes please indicate_____		
Was delivery assisted or otherwise unusual in any way? (please specify):		
Were forceps or vacuum used?		
Were there any medications or other drugs used during pregnancy? (please specify):		

Birth History	**yes**	**no**
Did the infant's mother experience any complications after birth?		
Did infant require feeding support after birth?		
Was the infant bottle fed?		
Did the infant demonstrate difficulties with sucking and/or swallowing?		
Were there complications such as: Jaundice?		
Apnea?		

Congenital defects or concern for genetic abnormality? (please specify):		
Any other concerns or notable differences during or immediately after birth?:		

Medical History :	**yes**	**no**
Does the individual have, or has he/she had any of the following: Ear Infections? Frequent? Please describe: PE tube placement? Date?		
Measles?		
Meningitis?		
Chicken Pox?		
Mumps?		
Whooping Cough (Pertussis)?		
Scarlet Fever?		
Diabetes?		
Cardiac abnormalities?		
Acute and/or Chronic Airway Disease such as asthma or recurrent bronchiolitis?		
Seizures? (please provide details)		
Allergies?		
Excessive vomiting?		
Tuberculosis?		
Polio?		
Physical Injuries/fractures/dislocations?		
Surgeries for any of the above or otherwise? (Please specify date		
Did your child receive evaluation for a visual problem? If yes, By whom? Is the report available? Please share any relevant details: If yes: does individual receive ongoing monitoring or therapy for this issue?		
Please provide details re: Evaluation provided by whom? _____ Date of Last evaluation: _____ Diagnosis, if any:_____ Is report available?		

Does the individual have any identified auditory issues? Evaluated by whom? _____ Date of Last evaluation:_____ Diagnosis, if any:_____ Is report available? Has your child ever received any auditory based training? Tomatis Method? Berard's Auditory Integration Training? ILS system?		
Is individual currently taking any medication? (please provide managing prescriber (DR.), type, amount, side effects or reactions):		
Does your child have a history of or ever been suspected of having seizure activity? If yes, please explain (and indicate whether the child is under management):		
Does your child have an IEP? If yes, please specify types of support.		
Please provide information regarding any other therapies or interventions your child has received in the past and/or is receiving now and include any additional details you feel are relevant for the purposes of this evaluation.		

Developmental History: **yes** **no**

Describe **infancy**-- was your infant: "easy going"? non- demanding?		
Fussy, irritable?		
Easy to calm?		
Difficult to calm?		

Able to maintain a state of quiet alertness to interact and engage with caregivers?		
Noted to avoid eye gaze, startle easily, and/or otherwise seem anxious?		
Happy when being held?		
Happier when left alone?		
Feel awkward to hold and almost stiff as if tense?		
Feel floppy?		
Sleep well, wake infrequently, go back to sleep easily?		
Have irregular sleep patterns; have difficulty getting to sleep or going back to sleep after waking?		

Developmental History: **yes** **no**

Did your child reach his/her developmental milestones on time to your knowledge? At what age did your child – roll over?_____ Crawl?_____ was crawl "normal" and reciprocal? Walk?_____ Coo/imitate facial expressions?_____ Babble?_____ Say first word?_____ String words together?_____ Feed self with a utensil?_____ Attempt to dress self with some success?_____ Ride a tricycle?_____		
Describe your **child presently**: Is he/she considered to be "easy going"?		
Easily agitated, difficult to please or easily thrown off (please describe):		
Able to self calm?		
Require ritual, another person, or item to calm down? (please specify):		
Sleep through the night without waking or able to get back to sleep if he/she is awakened?		
Have difficulty getting to sleep, staying asleep, and/or difficulty waking?		
Does the child snore and/or sleep with mouth open?		
Have limited attention span (that is unusual for the child's age and stage of development) for books or other activities requiring the child to attend to information?		
Noted to avoid eye contact?		
Does the child seem anxious some or most of the time?		
Does the child avoid or show little interest in activities that his/her friends are excited to join?		

Does the child appear to be clumsy and/or to frequently bump into things or people?		
Does the child appear to not experience pain as one would expect? (for example, fall and bump his/her head or skin his/her knees and not seem to notice?		
Does the child appear to be "on the go" or overly active most of the time?		
Do you or your family "dread" outings or avoid certain places/events because of how the child is expected to react to those situations? (please specify):		

Please use this space to share information regarding your child. What do you see as your child strengths? What concerns you most about your child's development?

Is there anything else you wish for us to know regarding your child?

_____

_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire!