CAPITAL KiDS
Occupational Therapy, LLC.

Developmental Questionnaire

Child's Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Sex: _____ Adopted: _____

Parent completing this questionnaire: _____

Current School: _____ Grade: _____

Teacher(s): _____

Prior Schools: _____ Grades Repeated: _____

Has he/she been in a special classroom, attended remedial or enrichment classes?

Please describe: _____

Mother's Name: _____

Address: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____

Fax: _____ Occupation: _____ E-mail: _____

Father's Name: _____

Address: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____

Fax: _____ Occupation: _____ E-mail: _____

Child's physician: _____ Phone number: _____

Address: _____

How long has your child been under this physician's care? _____

Has your child been diagnosed as having any medical or educational condition? _____

If so, what? _____

Who made this diagnosis and when was it made? _____

Referred by: _____ Relationship to child: _____

What are your concerns about your child? (Please provide a detailed explanation)

_____

_____

_____

Describe the hardest part of the day.

Describe the impact your child's struggles have on the family.

What are the school's primary concerns?

Is there any discrepancy in your impression of your child versus the school's?

Did either parent or any relative experience the same difficulties as your child? Explain:

Has your family experienced any recent crisis or stress that you feel is important to your child's development at this time? ___

What do you hope to gain from this evaluation?

General Information

Birth weight:_____lbs._____oz.

Pregnancy: Full Term: _____Premature: _____

Mother's health during pregnancy:_____

Were there any complications during pregnancy (illness, injury, stress, anemia, medications, etc): No Yes, Please explain
_____

Labor: Total length of labor: _____ Induced birth? _____ Breech Presentation? _____

Delivery: Vaginal: _____Cesarean: _____Forceps: _____Anesthesia: _____

Were there any complications during labor and delivery: _____
_____

Neonatal History: (*Check all that apply*)
Jaundice: _____Cyanosis: _____Limpness: _____Stiffness: _____
Congenital Defects: _____Oxygen: _____Transfusions: _____Tube Feedings: _____

Were there any feeding difficulties in the first month? _____
_____

Were any other problems encountered in the first month? _____
_____

Check all that describe your child as an **infant**:

☐Fussy, Irritable	☐Good, Non-Demanding
☐Quiet	☐Passive
☐Active	☐Liked being held
☐Resisted being held	☐Floppy
☐Tensed muscles when being held	☐Slept well
☐Irregular sleep patterns	☐Overly active, never still unless sleeping

Comments:_____
_____
_____

Approximate age at which your child did the following:

Raised head		Pulled to standing	
Crawled on hands and knees		Stood alone	
Sat alone		Walked	

List illnesses, injuries, or surgeries the child has had and age at the time of illness:
_____
_____

Has child had high fevers? _____Seizures: _____Frequency: _____
General health at present: Good: _____Fair: ____Poor: _____Describe: _____
List any present medications: _____
Ear infections: Yes: ____No: ____Frequency: ____Tubes: Yes: ___No: ____When: _____
Allergies: Yes: ____No: ____Type: _____
Does your child wear glasses? Yes: _____ No: ____
Any medical precautions? _____
Child's siblings: Sex and Age_____

Has your child received occupational therapy services in the past? Yes: __ No: __

Developmental History

Check all that describe your child most at **present**:

☐ Friendly	☐ Outgoing
☐ Eager learner	☐ Poor learning skills
☐ Difficulty reading	☐ Has difficulty ignoring irrelevant visual information
☐ Light sensitivity	☐ Poor balance
☐ Hypersensitive to sound	☐ Loves sports
☐ Fidgety and/or wiggly, especially when seated	☐ Loves to spin
☐ Easily becomes motion sick	☐ Physically timid (afraid to jump off places, go down slide)
☐ Biochemical or nutritional imbalance	☐ Allergies, frequent infection, low energy
☐ Adverse reaction to drugs	☐ Emotional sensitivity or instability
☐ Difficulty shifting from one activity to another	☐ Anxiety
☐ Exaggerated startle reaction	☐ Low self esteem
☐ Many fears	☐ Difficulty with change
☐ Difficulty making choices	☐ Toe walking
☐ Mostly quiet	☐ Poor sequence skills
☐ Over reacts	☐ Poor organizational skills
☐ Difficulty aligning number for math after age 6	☐ Overly active
☐ Bed wetting past 4 years	☐ Difficulty separating from primary caretaker
☐ Poor concentration	☐ Difficulty with bowel movements
☐ ADHD characteristics	☐ Poor handwriting
☐ Difficulty learning to ride a bicycle	☐ Difficulty multi-tasking after age 6
☐ Number letter reversal after age 7	☐ Tendency to slump when sitting
☐ Resistant to change	☐ Messy eater
☐ Difficulty learning how to swim after age 5	☐ Difficulty with sitting, falls often
☐ Anchors feet behind chair legs when sitting	☐ Cries often
☐ Difficulty with coordination, especially ball games	☐ Sensory issues such as difficulty tolerating tag, waistband of pants, food textures
☐ Heightened state of awareness, always on edge of "fight or flight"	☐ Reading & writing are easier when lying on the floor with legs extended

Your general impression of your child's motor development:

	Advanced	Normal	Slow
Gross Motor: Running, Jumping, Ball Play			
Fine Motor: Beading, Lacing, Cutting with scissors			
Handwriting/Coloring Skills:			

Sleeping

What time does your child awaken?							
What mood is your child in upon morning waking?							
What time is your child put to bed?							
What time does your child fall asleep?							
Where does your child sleep?							
Does your child have difficulty with sleeping?	No	Yes					
	Falling Asleep	Staying Asleep	Frequent night waking				
	Do family members have interrupted sleep as a result?	Yes	No				
	How would you rate severity of sleeping issues?						
How many times per night does he/she wake?	Almost never	1-2	3-4	5-6	7+		
What does your child do when he/she awakens?	Whimper	Screams	Plays with toys	Goes to parents' bedroom	Puts self back to sleep	Other(s)	
What activities do you use to get your child back to sleep? (Circle all that apply)	Feeding	Singing	Holding	Rocking	Bouncing	Massage	Other(s)
Describe your routines that are helpful for getting your child back to sleep.							
How old was your child when he/she consistently slept through the night?							
Does your child seem to require too much or too little sleep or at odd times?	No	Yes					
		How many hours nightly?					
		What times of day?					
Does your child take naps?	No	Yes					
		Frequency of naps?					
		Duration of naps?					
		Locations of naps?					
		Does child need help to fall asleep for naps?					
What activities do you use as part of your child's bedtime routine?	Bath time	Singing	Reading	Holding	Bouncing	Massage	Rocking	Other(s)
Please describe any necessary specifics regarding bedtime routine.	Specify:							
What happens if this routine is disrupted?	Impact on child:							
	Impact on family members:							

Feeding

Was your child breastfed as an infant?	No	Yes					
		For how long?					
If child was bottle fed as an infant were there any difficulties or concerns?	No	Yes. Please comment:					
Did your child have a strong suck as an infant?	No	Yes. Please comment:					
Did your child frequently spit up as an infant or have reflux?	No	Yes. Please comment:					
Did your child have problems with appetite or weight gain as an infant?	No	Yes. Please comment:					
Did your child have respiratory problems as an infant?	No	Yes. Please comment:					
Does your child refuse to eat, spit out, or gag on foods based on the following characteristics?	No	Yes					
		Temp	Food texture	Crunchy foods	Chewy foods	Food color	Mixed food textures
		Please comment:					

Does your child have difficulty with ingesting foods?	No	Yes					
		Chewing variety of foods	Sucking through a straw	Swallowing variety of foods	Food falling out of mouth	Frequent choking	Managing mixed food textures
		Please Comment:					
Is there a disruption in family mealtime as a result of atypical eating patterns?	No	Yes. Please comment:					
Does your child exhibit oral motor sensitivities or seeking?	No	Yes					
		Examines objects by placing in mouth	Gags/vomits frequently	Bites/Chews objects/clothing frequently	Grinds Teeth		
Does your child attempt to eat unusual, noxious, or inedible substances or place in mouth?	No	Yes. Please comment:					
Is your child able to sit during meals?	No	1-2 minutes	3-5 minutes	6-10 minutes	Entire meal		
		Does this impact the quantity of food ingested?		Yes	No		
		How does this impact harmony at mealtimes?					
		Please comment:					
Where does your child eat meals? Be Specific	Specify:						
What routines do you follow that are helpful for getting your child to eat meals?	Specify:						
Do you have concerns about your child's eating or food choices	☐ No						
	☐ Yes Please Comment:						

Grooming

Does your child dislike or resist **tactile feeling** of grooming activities?	Tooth Brushing	Bathing	Hair brushing combing	Face washing	Haircuts	Nail trimming	Blowing nose
Does your child have difficulty completing grooming activities in a **coordinated manner** or without adequate skill? (Check all that apply)	Tooth Brushing	Bathing	Hair brushing combing	Face washing	Haircuts	Nail trimming	Blowing nose
	Please comment:						
Does your child avoid or fear grooming devices? (Check all that apply)	Electric Toothbrushes	Barber's clippers	Dentistry tools	Nail Clippers	Other(s)		
	Please comment:						
Does your child avoid or fear the sounds associated with grooming activities? (Check all that apply)	Hair dryer	Bath water	Hand dryer	Toilet flushing			
What routines do you follow that are helpful for getting your child to participate in grooming activities?	Specify:						

Dressing

Which clothing is your child able to take off independently? (Check all that apply)	Shirt	Pants	Underwear	Shoes	Socks	Coat
Which clothing is your child able to put on independently? (Check all that apply)	Shirt	Pants	Underwear	Shoes	Socks	Coat

Which fasteners can your child manage independently? (Check all that apply)	Snaps	Zippers	Buttons (unbutton and button)	Ties Shoes Was it a struggle learning to tie?	
				No	Yes

Is your child selective in the types of clothing **textures** he/she will wear?	No	Yes What types of clothing textures are preferred? What clothing textures are avoided?
Does your child express a need for minimal clothing, regardless of weather?	No	Yes. Please comment:
Does your child express a need for clothing to cover entire body or dress in layers, regardless of weather?	No	Yes. Please comment:
Does your child frequently adjust clothing, as if uncomfortable?	No	Yes. Please comment:
Do tags in clothing or seams in socks bother your child?	No	Yes What type of reaction/behavior is seen?
What routines do you follow that are helpful for getting your child to participate with dressing?	Specify:	

Toilet Training

Is your child currently toilet trained for bladder?	No	Yes At what age?
Is your child currently toilet trained for bowel?	No	Yes At what age?

Does your child experience urinary/bowel issues? (Check all that apply)	Incontinence during the day	Bedwetting	Constipation	Loose stools	Lack of awareness
	How often?	How often?	How often?	How often?	How often?

Does your child wear a diaper or pull up at night?	No	Yes

What routines do you follow that are helpful for getting your child to participate in toileting?	Specify:
What happens if this routine is disrupted?	Impact on child: Impact on family members:

Social Functions/Family Living

Are you limited in attending family/social gatherings because of your child's behavior/reactivity to events?	No	Yes. Please comment (hyperactivity, safety awareness, fear of unknown, inability to tolerate crowds or noise, difficulty separating from parent):					
Is your child able to attend birthday parties?	Yes	No. Please comment:					
Is your child able to attend play dates at friend's houses?	Yes	No. Please comment:					
Are you able to leave your child alone with familiar, but not routine caregivers for childcare?	Yes	No. Please comment					
Will your child sleep over another child's house?	Familiar family member?	Grandparent?	Non-familiar family member?	Yes	No		
Is your family able to maintain relationships with other families?	Yes	No. Please comment:					
Is your family able to pursue hobbies and interests?	Yes	No. Please comment:					
Is your child able to tolerate social touch or hugs from others?	Yes	No. Please comment:					
Does your child have difficulty with different people's voices?	No	Yes					
		Loud voices	Men's voices	Women's voices	Children's voices	Screaming	Crying
What routines do you follow that are helpful for getting your child to participate in social situations?	Specify:						

Community

Is your child able to eat out at restaurants?	Yes. Please comment:		No	
Is your child uncomfortable on elevators, escalators, or in cars?	No	Yes. Please comment:		
Does your child avoid busy, unpredictable environments?	No	Yes. Please comment:		
Does your child have an excessive reaction to light touch sensation?	No	Yes		
		What types of reaction/behavior is seen?		
Is your child unresponsive to being touched or bumped?	No	Yes. Please comment:		
Does your child have an excessive reaction if bumped unexpectedly?	No	Yes. Please comment		
Are you concerned about your child's safety in the community?	No	Yes. Please comment		
Does your child have difficulty with loud, crowded sporting events?	No	Yes. Please comment:		
Is your child overly sensitive to lights or sunlight?	No Yes	Does your child dislike having eyes covered or being in the dark? Yes No	Does your child cover ears to shut out sound or overreact to unexpected noises? Yes No	Does your child avoid or seek certain smells? Yes No

Does your child have difficulty in the grocery store?	No	Yes. Please comment (impulsive, difficulty tolerating noise, light, temperature, choices):		
Does your child have difficulty in shopping malls?	No	Yes. Please comment:		
Does your child have difficulty with car sickness ?	No	Yes. Please comment:		
Does your child have difficulty standing in lines?	No	Yes. Please comment:		

Social Interaction

Does your child exhibit aggressive behavior?	No	Yes					
		Is it directed towards himself/herself?		No	Yes		
		Is it directed towards others?		No	Yes		
		What types of behaviors are exhibited? (Circle all that apply)	Biting	Pinching	Kicking	Hitting	Other(s)
Does your child exhibit tantrums?	No	Yes					
		How frequently do they occur? _____time/day or _____time/week					
		What triggers the tantrums?					
		On average, how long does a tantrum last?					
		Describe strategies that are effective for helping calm your child during a tantrum.					
		Are tantrums a source of distress to other family members?	No	Yes			
Is your child easily frustrated, anxious, or overwhelmed?	No	Yes. Please comment:					
Is your child overly dependent on parent(s) or clingy?	No	Yes					
		Are separations challenging?	No	Yes			
Does your child easily escalate from whimper to intense cry?	No	Yes. Please comment:					

If your child uses atypical repetitive behavior, which behaviors are demonstrated? (Check all that apply)	Hand flapping	Rocking	Head banging	Jumping	Smelling
	Breath holding	Humming	Self-talk	Biting	Mouthing objects
	Visual fixing	Spinning	Teeth grinding	Other(s)	

Does your child have difficulty with transitions such as getting dropped off at daycare/community activity or transitioning between activities?	No	Yes	
		What transitions are difficult?	Please comment:
		What strategies are used to help ease transitions?	Please comment:
Does your child struggle to communicate own needs?	No	Yes. Please comment:	

What is your child's primary form of communication?	Talking	Singing	Sounds/ Vocalizations	Pointing/ Gesturing	Crying
How often does your child make eye contact during conversation?	Less than 25%	25% of the time	50% of the time	75% of the time	100% of the time

Does your child lack fear of strangers?	No	Yes			
How does your child react in new/unfamiliar situations?	Specify:				
Does your child have difficulty paying attention in noisy environments?	No	Yes. Please comment:			
Does your child cover ears to shut out objectionable auditory input or overreact to unexpected noises?	No Yes	Does your child hear sounds that others do not or before others notice? Yes No	Does your child demonstrate an irrational fear of noises? Yes No		
Does your child regularly avoid initiation of social interaction?	No	Yes			
		With whom?			
		How often?			
Does your child avoid maintaining social interaction?	No	Yes			
		With whom?			
		How often?			
Does your child experience difficulties with language expression? (Circle all that apply)	No	Yes			
		Easily frustrated	Frequently mispronounces words (ie bisghetti)	Poor articulation, difficult to understand	Difficulty making choices
		Flat, monotonous voice	Hesitant speech	Tendency to stutter	Difficulty expressing emotions verbally

Play skills/Peer Interaction

How long is your child able to play alone?	1-2 minutes	2-5 minutes	5-10 minutes	10-30 minutes	30+ minutes	
What are your child's preferred play activities?	Specify:					
How much time is spent daily in the following activities?	Passive activities (ie TV, computer, etc.)		Movement activities (ie playground, roughhouse play, etc)		Learning/interactive play	
Is your child destructive towards toys?	No	Yes. Please comment:				
Does your child struggle to play alone (excluding TV watching?	No	Yes. Please comment:				
Is your child able to engage in "pretend play?"	No	Yes				
Does your child struggle playing with other children? (Check all that apply)	No	Yes				
		Parallel play- playing alongside other children	Interactive play- playing with other children	Structure group play	Making friends	Pretend play
Is your child preoccupied with seeking intense movement during play? (Check all that apply)	No	Yes				
		Spinning	Bouncing	Crashing	Jumping	Rocking	Other(s)
Does your child tend to play with children who are:	Same Age		Younger		Older	
Does your child have a strong desire for structure or control?	No	Yes. Please comment:				
Does your child struggle to play in familiar settings?	No	Yes. Please comment:				

Does your child struggle to play in unfamiliar settings?	No	Yes. Please comment:				
Which playground equipment will your child play on? (Check all that apply)	Swings	Monkey bars	Crawl tunnel	Vertical climbers	Merry-Go-round	Ladders
	Slide	Climbing wall	Bridges	Tetter totter	Spring riders	Other(s)
Which playground equipment does your child avoid? (Check all that apply)	Swings	Monkey bars	Crawl tunnel	Vertical climbers	Merry-Go-round	Ladders
	Slide	Climbing wall	Bridges	Tetter totter	Spring riders	Other(s)
Does your child avoid certain types of toys (ie textured toys)?	No	Yes. Please comment:				
Does your child exhibit poor safety awareness or engage in activities that are potentially dangerous (ie jumping without regard)?	No	Yes. Please comment:				
Which of the following "messy" activities does your child avoid? (Check all that apply)	Sand	Playing in the grass	Finger paint	Play-doh	Glue	Other(s)

Which surfaces does your child have difficulty with? (Check all that apply)	Ascending stairs	Descending stairs	Grass	Gravel driveways	Wood-chips	Sand	Other(s)
Does your duck or blink when ball is thrown at him/her?	No	Yes. Please comment:					
Which gross motor skills does your child have difficulty with in comparison to age peers?	Hopping	Jumping	Skipping	Running	Riding a tricycle/ bicycle		

School Skills

Where does your child attend preschool or school?	Home school	Daycare	Special needs pre-school class	Regular education class	Special education class	Other	
Does your child exhibit a hand preference?	No	Yes					
		Right			Left		
		Established at what age?					
Does your child frequently change his/her grasp on pencils/other tools?	No	Yes					

Which writing skills does your child struggle with/avoid? (Check all that apply)	Drawing/ coloring	Tracing	Copying	Handwriting	Use of graded pressure		Stabilization of paper while drawing/ writing	Proper writing posture
					Too much	Too little		

Which fine motor skills does your child struggle with/avoid? (Check all that apply)	Grasping and maneuvering scissors	Performing 2 different tasks at the same time (ie hold and turn paper while cutting, cut food using knife and fork)	
	Opening containers	Snaps or zippers	Spin a top
	Playing with toys such as legos	Using silverware	Cutting with a knife

Which skills does your child struggle with? (Check all that apply)	Finding items within a "hidden	Telling time	Sequencing months of the year	Puzzles and construction/ manipulation of materials	Spelling	Responding promptly to verbal instruction	Writing numbers & letters correctly

	picture"						(without frequent reversals)
Are your child's drawings immature for age?	No	Yes. Please comment:					
Does your child write up/down hill on paper?	No	Yes. Please comment:					
Which of the following visual related skills does your child struggle with? (Check all that apply)	Short attention for reading/copying	Rereads or skips words	Needs finger to keep place while reading	Closing/covering one eye while doing near work	Excessive blinking or rubbing of the eyes		
	Copying from board to paper	Keeps eyes too close to work	Turning head when reading across a page	Losing place often during reading	Reading comprehension		
Does your child have difficulty sitting still?	No	Yes					
		Does your child fidget while listening?		No	Yes		

Movement Skills

Does your child become overly excited after movement activities?	No	Yes. Please comment:	
Does your child like to be wrapped tightly in a sheet or blanket, or seeks tight spaces?	No	Yes	
Does your child shake head vigorously or assume an upside down position frequently?	No	Yes	
Is your child able to conceive and organize a plan of action to direct play/movement?	No	Yes	
Does your child display the following movement difficulties? (Check all that apply)	Avoids activities where feet leave the ground	Avoids/fears activities requiring balance	Avoids age appropriate gross motor activities
	Excessive dizziness from swinging, spinning, or riding in a car	Stamps/slaps feet on ground when walking	Loses balance/trips easily or frequently
	Resists having head tilted backwards	Drags hand or bangs object along wall when walking	Unable to reciprocate feet on stairs
	Fears falling when no real danger exists	Lethargic or inactive	Confuses left and right
	Fearful of being tossed in the air or turned upside down	Leans on objects/people for stability	Dislikes being moved
	Holds head upright when leaning or bending over	Seems weaker or tires more easily than peers	Moves with quick bursts of activities rather than sustained effort
	Dislikes being upside down	Poor sense of direction or awareness of space in relation to self	Poor coordination or sense of rhythm