DEVELOPMENTAL PEDIATRICS
2210 Lelaray
Colorado Springs
CO 80909

Date:_____

DEVELOPMENTAL HISTORY

Child's Name:_____**DOB:**_____ **(mm/dd/yyyy)**

Mother's Name:_____ **Father's Name:**_____

Siblings:

Name:_____Age:_____ Name:_____Age:_____

Name:_____Age:_____ Name:_____Age:_____

Languages spoken in the home:_____

Birth History

Length of Pregnancy:_____weeks (40 = Full Term) Length of Labor:_____hours

Baby's Birthweight:_____ APGAR Scores:_____

Was your baby in a special care nursery(NICU)? ☐Yes ☐No If yes, where?_____

Describe the labor & delivery if other than typical:

_____

_____

_____

Did your baby require ventilation or supplemental oxygen? (Describe how much and for how long.)

_____

_____

_____

Describe any other pertinent medical procedures or problems after birth (jaundice, dehydration, etc.)

_____

_____

_____

Was (or is) your baby breast fed?_____ Until what age?_____

Was there difficulty with nursing? ☐Yes ☐No

If your child is currently nursing or bottle feeding: How often:_____

Formula:_____ Amount Taken:_____

(if nursing, minutes each breast)

Does your baby/child have difficulty with feeding such as choking, gagging or other problem? ☐Yes ☐No

Describe:_____

_____

_____

Is your baby/child a picky eater? ☐Yes ☐No

What foods does your child
Like:_____

_____

_____

Dislike:_____

_____

_____

Health History

Allergies or Food Intolerances:_____

Medications:_____

Childhood Illnesses:_____

Hospital Stays/Surgeries/Injuries:_____

Do you have concerns about vision? ☐Yes ☐No (Date of last exam, If any)_____

Name of Ophthalmologist/Optometrist:_____

Do you have concerns about hearing? ☐Yes ☐No (Date of last exam, If any)_____

Name of Audiologist:_____

Ear-Infections? ☐Yes ☐No How many?_____

History of hearing loss in the family? ☐Yes ☐No _____

Has any family member had a history of hearing or speech/language problems? ☐Yes ☐No

_____

Are there any problems with the oral or facial structures or any extremities? ☐Yes ☐No

_____

Present health status:_____

Social Activity

What are your child's favorite activities?_____

_____

What does your child like to play with?_____

_____

Who does your child like to play with?_____

_____

How do you discipline your child?_____

_____

Is it effective?_____

Development

Have you previously had concerns about your child's development? ☐ Yes ☐ No

Describe:_____

_____

_____

Were developmental milestones achieved: Early ☐ Average ☐ Almost Never ☐

Did/does your baby like to play on his/her stomach? ☐ Yes ☐ No

My baby's favorite position is:_____

Did/Does your baby crawl? ☐ Yes ☐ No ☐

My baby/child cries or becomes upset: Easily ☐ Average ☐ Almost Never ☐

My baby calms with: Rocking ☐ Bouncing ☐ Swinging ☐ Swaddling ☐ Other ☐ Doesn't calm ☐

My baby/child communicated with us by: ☐ Different types of cries ☐ Facial Expressions ☐ Making Sounds

☐ Body Movements ☐ Making Sounds ☐ Looking ☐ Gestures ☐ 1-2 words ☐ Phrases ☐ Sentences

Has your baby/child been evaluated or received therapy services in the past? ☐ Yes ☐ No

If yes, describe:_____

_____