

SENSORIMOTOR HISTORY

Child's Name _____ DOB _____ Date _____

Please think of the various stages of your child's development, considering behavior which comes to your mind as you answer these questions. What do you think of as being different from other children you know? Were there times when his/her behavior was difficult to cope with in the family unit?

The following questions are posed to help in compiling a more complete picture of your child from early infancy to present developmental stage. Some of these questions may refer to children who are older than your own. Kindly cross out the verb tense that does not apply. Check the choice which applies: Yes, No, Used To, or N/A (not old enough yet, or for other reasons, nonapplicable.) Add narrative information which would also be important on the back. Thank you for your cooperation.

MOTHER'S HEALTH DURING PREGNANCY

	YES	NO
Did Mother:		
1) Have any infections/illnesses during pregnancy. Describe: _____	_____	_____
2) Have any shocks or unusual stress during pregnancy _____	_____	_____
3) Water break more than 24 hours before delivery _____	_____	_____
4) Develop toxemia/high blood pressure? When _____	_____	_____
5) Have any complications during delivery and/or labor? _____	_____	_____
6) Mother's age at delivery _____		
7) Number of Prev. miscarriages _____		
8) If premature, how many weeks? _____		
9) Child's birth weight? _____		
10) Child's weight at discharge _____		
11) Apgar scores:		
1 minute _____		
5 minute _____		

CHILD'S BIRTH

	YES	NO
Was or did child:		
1) Full term _____	_____	_____
2) Premature _____	_____	_____
3) Cesarean Section _____	_____	_____
4) Breech (feet first) _____	_____	_____
5) Face presentation _____	_____	_____
6) Transverse (sideways) _____	_____	_____
7) Have cord wrapped around neck _____	_____	_____
8) Require forceps _____	_____	_____
9) Have birth injuries _____	_____	_____
10) Require a fetal monitor _____	_____	_____
11) Insufficient oxygen _____	_____	_____
12) Cry right away _____	_____	_____
13) Need intensive care Hospitalization? _____	_____	_____
a. How long _____		
b. Prematurity _____	_____	_____
c. Respiratory problems _____	_____	_____
d. Need respirator _____	_____	_____
How long? _____		
e. Small for gestat'l age _____	_____	_____
f. Heart defect _____	_____	_____
g. Need exch. transfusion _____	_____	_____
h. Jaundiced _____	_____	_____
How long under lights _____		
i. Have congenital abnormalities _____	_____	_____
j. Have seizures _____	_____	_____
k. Have infecgion at birth _____	_____	_____
l. Have surgery as a newborn _____	_____	_____
m. Have feeding problems as a newborn _____	_____	_____

SENSORIMOTOR HISTORY**TASTE & SMELL****YES NO USED TO N/A**

Does child:

- | | | | | |
|---|-------|-------|-------|-------|
| 1) Act as though all food tastes the same | _____ | _____ | _____ | _____ |
| 2) Explore with taste | _____ | _____ | _____ | _____ |
| 3) Chew on non-food items | _____ | _____ | _____ | _____ |
| 4) Have any feeding problems | _____ | _____ | _____ | _____ |
| 5) Have trouble changing to textured foods | _____ | _____ | _____ | _____ |
| 6) Sensitive to any unusual smells | _____ | _____ | _____ | _____ |
| 7) Taste or smell toys, cloths, etc more than usual | _____ | _____ | _____ | _____ |

AUDITORY (sound)**YES NO USED TO N/A**

Does child:

- | | | | | |
|--|-------|-------|-------|-------|
| 1) Have a diagnosed hearing problem | _____ | _____ | _____ | _____ |
| 2) Have PE tubes in ears | _____ | _____ | _____ | _____ |
| 3) Have frequent ear infections | _____ | _____ | _____ | _____ |
| 4) Seem too sensitive to sound | _____ | _____ | _____ | _____ |
| 5) Respond negatively to unexpected sounds | _____ | _____ | _____ | _____ |
| 6) Have fears of any particular sounds | _____ | _____ | _____ | _____ |
| <hr/> | | | | |
| 7) Distracted by sounds such as refrigerator, fans, fluorescent light bulbs, heaters, etc. | _____ | _____ | _____ | _____ |
| 8) Miss some sounds or words | _____ | _____ | _____ | _____ |
| 9) Fail to listen, or pay attention to what is said | _____ | _____ | _____ | _____ |
| 10) Seem to be confused about what direction sounds come from | _____ | _____ | _____ | _____ |
| 11) Like to make loud noises | _____ | _____ | _____ | _____ |
| 12) Like to sing and/or dance to music | _____ | _____ | _____ | _____ |
| 13) Have difficulty copying rhythmic sounds | _____ | _____ | _____ | _____ |
| 14) Fail to follow through to act upon requests to do something, to understand directions | _____ | _____ | _____ | _____ |
| 15) Unable to function if 2 or 3 steps of instructions are given at once | _____ | _____ | _____ | _____ |
| 16) Talk excessively | _____ | _____ | _____ | _____ |
| 17) Talking interferes with his/her listening | _____ | _____ | _____ | _____ |
| 18) Have a delay in speech development | _____ | _____ | _____ | _____ |

MUSCLE TONE**YES NO USED TO N/A**

Does child:

- | | | | | |
|--|-------|-------|-------|-------|
| 1) Feel heavier than he/she looks | _____ | _____ | _____ | _____ |
| 2) Have good endurance | _____ | _____ | _____ | _____ |
| 3) Have any diagnosed muscle problems | _____ | _____ | _____ | _____ |
| 4) Have flat feet | _____ | _____ | _____ | _____ |
| 5) Slump when sitting | _____ | _____ | _____ | _____ |
| 6) Get tired easily | _____ | _____ | _____ | _____ |
| 7) Seem generally weak | _____ | _____ | _____ | _____ |
| 8) Keep mouth open | _____ | _____ | _____ | _____ |
| 9) Prefer to lie on back rather than stomach | _____ | _____ | _____ | _____ |

COORDINATION

Does child:	YES	NO	USED TO	N/A
1) Sit, stand or walk late	_____	_____	_____	_____
2) Sit, stand or walk early	_____	_____	_____	_____
3) Was creeping/crawling phase unusually long	_____	_____	_____	_____
4) Was creeping/crawling phase basically omitted	_____	_____	_____	_____
5) Are movements slow, prodding, deliberate	_____	_____	_____	_____
6) Play with toys appropriately for age	_____	_____	_____	_____
7) Have difficulty with sequential tasks; dressing buttoning, zipping, shoe tying	_____	_____	_____	_____
8) Clumsy playing with toys	_____	_____	_____	_____
9) Have difficulty learning to hold a pencil or crayon in a 3-point position	_____	_____	_____	_____
10) Creep on tummy or bottom	_____	_____	_____	_____
11) Trip or fall alot	_____	_____	_____	_____
12) Seem clumsy, awkward	_____	_____	_____	_____
13) Bump into things alot	_____	_____	_____	_____
14) Have a dominant hand	_____	_____	_____	_____
15) Have poor handwriting	_____	_____	_____	_____
16) Handle small things easily	_____	_____	_____	_____
17) Eat neatly for age	_____	_____	_____	_____
18) Have rigid movements	_____	_____	_____	_____
19) Grimace or use tongue in fine motor tasks	_____	_____	_____	_____
20) Get shaky in fine motor tasks	_____	_____	_____	_____
21) Enjoy sports, gym, etc	_____	_____	_____	_____

VESTIBULAR (movement)

Does Child:	YES	NO	USED TO	N/A
1) Arch back when held or moved	_____	_____	_____	_____
2) Enjoy being rocked	_____	_____	_____	_____
3) Like being tossed in the air	_____	_____	_____	_____
4) Like fast spinning carnival rides	_____	_____	_____	_____
5) Like to swing	_____	_____	_____	_____
6) Spin or whirl more than other children	_____	_____	_____	_____
7) Get carsick easily	_____	_____	_____	_____
8) Get nauseous and/or vomit from other movement experiences	_____	_____	_____	_____
9) Rock while sitting	_____	_____	_____	_____
10) Jump alot	_____	_____	_____	_____
11) Have fear in space (stairs, heights)	_____	_____	_____	_____
12) Lose balance easily	_____	_____	_____	_____
13) Walk on toes (not flat feet)	_____	_____	_____	_____
14) Misunderstand meaning of words used in relation to movement or position	_____	_____	_____	_____

SENSORIMOTOR HISTORY

TACTILE	YES	NO	USED TO	N/A
Does Child:				
1) Like to be touched	_____	_____	_____	_____
2) Dislike being held or cuddled	_____	_____	_____	_____
3) Prefer to touch rather than be touched	_____	_____	_____	_____
4) Seem excessively ticklish	_____	_____	_____	_____
5) Seem easily irritated or enraged when touched by siblings or playmates	_____	_____	_____	_____
6) Have a strong need to touch objects and people	_____	_____	_____	_____
7) Seem to pick fights	_____	_____	_____	_____
8) Pinch, bite or otherwise hurt self or others	_____	_____	_____	_____
9) Frequently bump or push others	_____	_____	_____	_____
10) Bang head on purpose	_____	_____	_____	_____
11) Like to touch animals	_____	_____	_____	_____
12) Dislike the feeling of certain clothing	_____	_____	_____	_____
13) Over or under dress for the temperature	_____	_____	_____	_____
14) Overheat easily	_____	_____	_____	_____
15) Seem overly sensitive to food/water temperature	_____	_____	_____	_____
16) Seem overly sensitive to rough food textures	_____	_____	_____	_____
17) Prefer bath over showers if choice is available	_____	_____	_____	_____
18) Like to play in water, mud, sand, clay, etc	_____	_____	_____	_____
19) Seem to lack normal awareness of being touched	_____	_____	_____	_____
20) Often seem unaware of cuts, bruises, etc until brought to his/her attention	_____	_____	_____	_____
21) Avoid objects of clothes with hands	_____	_____	_____	_____
22) Examine objects or clothes with hands	_____	_____	_____	_____
23) Mouth objects or clothes excessively	_____	_____	_____	_____

LEARNING STYLES	YES	NO	USED TO	N/A
Does Child:				
1) Recognize own errors	_____	_____	_____	_____
2) Learn from mistakes	_____	_____	_____	_____
3) Acquire materials needed for a task	_____	_____	_____	_____
4) Able to set up a work space	_____	_____	_____	_____
5) Maintain work space	_____	_____	_____	_____
6) Able to work independently	_____	_____	_____	_____
7) Generalize known skills to acquire new skills	_____	_____	_____	_____
8) Demonstrate age appropriate memory	_____	_____	_____	_____
9) Ask for help appropriately	_____	_____	_____	_____
10) Plan ahead	_____	_____	_____	_____
11) Create new ideas and ways of doing thing	_____	_____	_____	_____
12) Age appropriate content in written language	_____	_____	_____	_____
13) Gets work done on time	_____	_____	_____	_____
14) Average reading level	_____			
15) Average math level	_____			

SENSORIMOTOR HISTORY

BEHAVIOR/TEMPERAMENT

YES NO USED TO N/A

Does or is Child:

- 1) Quiet, calm relaxed, patient _____
- 2) Active, outgoing, enthusiastic _____
- 3) Intense, easily frustrated, anxious _____
- 4) Explosive _____
- 5) Seem hyperactive, always in perpetual motion _____
- 6) In the same mood all day as when he/she wakes _____
- 7) An early riser, immediately on the go _____
- 8) Cry excessively in infancy _____
- 9) Clingy _____
- 10) Predictable _____
- 11) Rigid, set in ways _____
- 12) Adaptable, flexible _____
- 13) Regular sleep patterns _____
- 14) Difficult to get to sleep _____
- 15) Wakes frequently _____
- 16) Screams when wakes during the night _____
- 17) Able to play alone for a reasonable length of time _____
- 18) Destructive with toys _____
- 19) Short attention span _____
- 20) Distractible _____
- 21) Difficulty making a choice _____
- 22) Demonstrate self stimulating behaviors _____
- 23) Have frequent tantrums _____
- 24) Display extreme mood changes _____
- 25) Unable to adjust to routine change _____
- 26) Aggressive, acting out behaviors _____
- 27) Make friends easily _____
- 28) Prefer the company of adults or older children _____
- 29) Prefer playing with children 1-2 years younger _____
- 30) Seem to be a loner _____
- 31) Express feelings of low self-esteem _____
- 32) Express feelings of failure and frustration _____
- 33) Seem discouraged or depressed _____

VISUAL

YES NO USED TO N/A

Does Child:

- 1) Have a diagnosed visual problem _____
- 2) Seem very sensitive to light _____
- 3) Have trouble following with eyes _____
- 4) Avoid eye contact _____
- 5) Distracted by visual stimuli _____
- 6) Dislike having eyes covered _____
- 7) Able to close eyes for short periods _____
- 8) Make reversals when copying or reading _____
- 9) Like playing in the dark _____
- 10) Have trouble discriminating shapes or colors _____
- 11) Squint often _____
- 12) Able to look at something far away _____
- 13) Able to look at something close _____