PREGNANCY/BIRTH HISTORY

Length of pregnancy: _____

List any medications taken during pregnancy: _____

_____

Did the mother experience any complications during pregnancy? _____

_____

Weight at birth? _____ APGAR Score (if known) _____

Place of birth: _____

Birth conditions (circle applicable): Vaginal C-Section Breech Forceps

Did your baby spend time in NICU? Yes ☐ No ☐ How long? _____

CURRENT CONCERNS

Please describe your main concerns about your child's development (e.g. hearing, language, learning, motor skills, sensory issues, sleeping or eating issues, sleeping or eating issues, or behavioral/emotional concerns, etc.) and any questions you would like answered through the evaluation:

_____

_____

_____

Has your child's vision been evaluated? Yes ◯ No ◯

If so, when and where? _____

Results? _____

Has your child's hearing been evaluated? Yes ◯ No ◯

If so, when and where? _____

Results? _____

History of any ear infections? _____

Has your child had medical/surgical treatment for ears? Yes ◯ No ◯

If so, when and why? _____

DEVELOPMENT

At what approximate age did your child:

_____ Roll from stomach to back

_____ Crawl

_____ Walk alone

_____ Complete potty-training

_____ Say first word

_____ Sit alone without support

_____ Stand alone

_____ Feed self with spoon

_____ Babble w/ consonants ("bad a ma")

_____ Combine words-short sentences

Does your child understand what you say? _____

Do you understand what your child says? _____

In general, how would you describe your child's development?

Delayed _____ Average _____ Above Average _____

MEDICAL INFORMATION

Please list any over the counter or prescriptions child is taking: _____

_____

List any allergies: _____

_____

List any surgeries: _____

_____

Has your child had any chronic illnesses? If so describe: _____

_____

Does your child experience any of the following?

Frequent falling? _____ Clumsiness? _____ Frequent colds? _____

Has your child been in therapy before? _____

If so, please select which discipline: (circle) Occupational Physical Speech ABA

What clinic did they go to before, and when? _____

_____

_____

Do you feel your child made progress? _____

SCHOOL HISTORY

Where does your child attend school or daycare? _____

What grade? _____ Does your child receive therapy through school? Yes ____ No ____

If yes, what services are provided? _____

PERSONALITY/INTERESTS

Behavioral characteristics:

- ____ Cooperative
- ____ Attentive
- ____ Willing to try new activities
- ____ Short attention span
- ____ Plays alone for reasonable time
- ____ Separation difficulties
- ____ Stubborn
- ____ Other: _____
- ____ Restless
- ____ Poor eye contact
- ____ Easily distracted
- ____ Destructive/aggressive
- ____ Withdrawn
- ____ Inappropriate behavior
- ____ Self-abusive behavior

How do you discipline your child? _____

What methods of discipline have been or are currently utilized by your family or other professionals? _____

_____

Do you feel that the methods are effective? _____

Please describe your child's current interests: _____

_____

What hand does your child prefer? Right ◯ Left ◯ Both ◯

ADLS

Is your child able to dress independently? _____

If your child requires assistance what does your child need help with? _____

_____

Is your child able to perform hygienic tasks independently (i.e. brush teeth, brush hair, bathe/shower, and toileting)? _____

Does your child sleep well? _____ Do they have to take medication to sleep? _____

If so, what? _____

FEEDING/ORAL MOTOR

Is your child a "picky eater"? _____

If yes, list the foods the child:

DOES eat: _____

DOES NOT eat: _____

Do you feel lack of nutrition is a factor in your child's development? _____

Has your child ever had difficulties with chewing or swallowing his/her food? Yes ◯ No ◯

If yes, please explain: _____

_____

SPEECH

How many words are in your child's vocabulary? _____

Does your child know colors? _____ Letters? _____ Numbers? _____

How does your child communicate his/her wants/needs? Which of the following is used: (circle)

Words Phrases Sentences Gestures Pointing Taking you to objects

Asking for help Calling to get your attention Asking questions

How well can you understand him/her? (1 = not at all, 5 = all the time)

1 2 3 4 5

Does your child follow directions?

_____ Simple (i.e. come here, give me)

_____ Social routines

_____ Two step (i.e. Get your shoes and bring then to me)

_____ Three step (i.e. Get your shoes, bring them to me, and sit down)

Attention (how long can child typically attend to task/game/activity): _____

How does your child play/interact with peers and/or siblings? _____

_____

Does your child play appropriately with toys? _____

ADDITIONAL INFORMATION

Please include any information that you feel would be helpful to therapist treating your child.

_____

_____

_____

_____