\*Patient Name: Today’s Date:

\*Date of Birth: Soc. Security #: \*Gender: Male Female

Ethnicity: Religion: Primary Language:

\*Home Address:

**\*Primary Phone #**: ­

\*Parent 1 Name: DOB:

Parent 1 Address if different from patient:

Parent 1 Primary Phone #: Other Phone #:

Parent 1 Employer: Occupation:

 \*Parent 2 Name: DOB:

Parent 2 Address if different from patient:

Parent 2 Primary Phone #: Other Phone #:

Parent 2 Employer: Occupation:

Siblings Names & Ages:

**\*Person completing this form: \*Relationship to Patient:**

\*Primary Care Physician (PCP): PCP Phone:

\*Referring Physician: Ref. Physician Phone:

Specialist Physician: Spec. Physician Phone:

Are you transferring from another Facility? Yes / No If yes, Please name facility:

\*Patient Preferred Language:

Parent 1 Primary Language: Preferred language:

Parent 2 Primary Language: Preferred language:

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| **Professional Evaluations** |
| Has your child been evaluated by any of the following? (Please check all that apply and provide copies of reports) |
|  | **Evaluations** | **Provider Name** | **Evaluation Date** | **Diagnosis** |
| **Developmental Pediatrician** | Yes | No |  |  |  |
| **Neurologist** | Yes | No |  |  |  |
| **Orthopedic**  | Yes | No |  |  |  |
| **Physical Therapist** | Yes | No |  |  |  |
| **Occupational Therapist** | Yes | No |  |  |  |
| **Speech Therapist** | Yes | No |  |  |  |
| **Counseling** | Yes | No |  |  |  |
| **Other:** | Yes | No |  |  |  |
| **Hospitalizations and/or Surgeries** |
| **Date** | **Reason** | **Location** |
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| **Child’s typical weekly routine** |
| Attends:  | Daycare | Preschool | School |
| Facility Name:  |  | Grade/Classroom Type:  |  |
| Days and Times:  | Monday\_\_\_\_\_ Tuesday\_\_\_\_\_ Wednesday\_\_\_\_\_ Thursday\_\_\_\_\_ Friday \_\_\_\_\_ |
| Support Services (Include days and times): |  |
| Extracurricular Activities (Include days and times): |  |

**What are your primary concerns?**

**What are your therapy goals for your child?**

**What are your therapy goals for your family?**

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| Patient’s birth weight: |  | Patient’s current weight: |  |
| Patient’s length at birth: |  | Patient’s current Length:  |  |
| Apgars: |  | Weight Percentile: |  |
| Length of pregnancy (gestational age) |  | Head Circumference: |  |

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| **Birth History:** |
| First Child? | Yes | No |  Birth Order: |
| Single or Multiple Birth? | Single | Multiple \*\* | \*\* If Multiple Birth: Twin A or Twin B |
| Born Prematurely? | Yes\*\* | No |  |
| \*\*\*Did your child require any of the following:  | NICU | Incubator | Special Care Nursery | Oxygen |  |
| Complications during pregnancy? | Yes\*\* | No | \*\* If Yes, Please List: |
| Complications during Delivery? | Yes\*\* | No | \*\* If Yes, Please List: |
| Mother’s age at birth? |  | Child’s Utero Position |  |
| Delivery: | Vaginal | C-Section | Vacuum | Nuchal Cord | Other: |
| Infant Position at Birth: | Vertex | Breech | Transverse | Unknown | Other: |
| Duration of Labor |  | How long did Mother push? |  |
| Known Uterine Abnormalities for Mother? | Yes\*\* | No | \*\* If Yes, Please describe: |
| Fertility Treatments? | Yes\*\* | No | \*\* If Yes, list fertility medications: |
| Other Medications taken during pregnancy | Yes\*\* | No | \*\* If Yes, Please list: |
| Medications taken during delivery | Yes\*\* | No | \*\* If Yes, Please list: |
| Did child seem stuck in one position for the last part of pregnancy? | Yes\*\* | No | \*\*If Yes, Please describe: |
| OB/Gyn and or Mid-Wife |  |
| Hospital/Birth Center where child was born? |  |
| Results of Newborn Hearing Screening | Pass | Fail\*\* | \*\* If fail, what were results? |
| Did the child receive therapy services prior to discharge from hospital? | Yes\*\* | No | \*\*If Yes, Please describe: |
| **Infant/Child Positioning** |
| Does the infant have a head tilt? | Yes | No | \*\*If Yes, Right or Left |
| Rotation preference? | Yes | No | \*\*If Yes, Right or Left |
| Has the child ever been treated for Torticollis? | Yes \*\* | No | \*\*If Yes, when was treatment? |
| Any other children with tight neck muscles and or misshapen head? | Yes \*\* | No | \*\* If Yes, Please explain: |
| Did child have a normal head shape at birth? | Yes | No\*\* | \*\*If No, Please explain: |
| Who noticed misshapen head? |  | What age was misshapen head noticed? |  |
| When did doctor diagnosis misshapen head? |  |
| Any facial asymmetry? | Yes\*\* | No |  |
| Time child spends in car seat per day? |  | Type of car seat: |
| Time Child spends in Swing per day? |  | Time child in other sitting devices per day? |  | Type of sitting device: |
| Time child spends on back daily: |  | How often is child held: |  | What position is child held? |  |
| Age initiated belly time? |  | Time child pends on belly daily? |  | Belly increments per day? |
| Child’s sleep position(birth – 1 year): | **Supine****(on back)** | **Side** | **Prone****(on tummy)** | **Other:** |
| Child’s current sleep position(1 year and older): | **Supine****(on back)** | **Side** | **Prone****(on Tummy)** | **Other:** |
| Typical sleep hours per night(birth – 1 year): |  | Typical sleep hours per night(1 year and older): |  |
| Does the child have difficulty falling or staying asleep? | Yes | No | Does the child snore? | Yes | No |
| Do you have any concerns with your child’s sleep pattern? |  |
| **Diagnostic Tests** |
| X- Ray | Yes | No |  |
| MRI | Yes | No |  |
| CT Scan | Yes | No |  |
| Ultra Sound | Yes | No |  |
| Swallowing Study | Yes | No |  |
| Has your child had a vision evaluation | Yes\*\* | No | \*\*If yes, what were the results |
| Has your child had a hearing evaluation? | Yes\*\* | No | \*\* If yes, what were the results |
| **Congenital Anomalies** (circle any that apply) |
| Hip Dysplasia | Yes | No | Right | Left |  |
| Hip Subluxation | Yes | No | Right | Left |  |
| Fractured clavicle | Yes | No | Right | Left |  |
| Forceps Abrasion | Yes | No | Right | Left |  |
| Brachial Plexus injury | Yes | No | Right | Left |  |
| Cephalohematoma | Yes \*\* | No | \*\*If yes, please circle below |
|  | Parietal | Right | Left | Small / Medium / Large |
| Occipital | Right | Left | Small / Medium / Large |

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| **Early Milestones Developmental (list the age in months)** |
| Mouthing of toys/hands: |  | Sat without support: |  |
| Held head up: |  | Started crawling: |  |
| Rolled over: |  | Started walking: |  |
| Started babbling: |  | Walking independently: |  |
| Toilet trained: |  |  |  |

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| **Early Feeding History** |
| Was Child Breast Feed? | Yes\*\* | No | Length of time child breastfed? |
| When did Child start using a bottle |  |
| When did child start using formula? | Yes\*\* | No | Type of formula? |
| Did your child have trouble feeding? | Yes\*\* | No | \*\*If Yes, explain: |
| Tongue/Lip tie | Yes\*\* | No | \*\*If yes, was it clipped?  |
| Was Child Breast Feed? | Yes\*\* | No | Length of time child breastfed? |
| History of Reflux | Yes\*\* | No | \*\* If Yes, how is it managed? |

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| **Physical Therapy Questions** |
| Does your child use braces? | Yes\*\* | No | \*\*If Yes, explain: |
| Does your child use orthotic? | Yes\*\* | No | \*\*If Yes, explain: |
| Does your child use any assistance devices? | Yes\*\* | No | \*\*If Yes, explain: |
| Has your child seen an orthopedic doctor?  | Yes\*\* | No | \*\*If yes, Who? When? Why? |

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| **Occupational Therapy Questions: Fine Motor/Play** |
| Are you worried about your child’s play skills? | Yes\*\* | No | \*\*If Yes, explain: |
| Does your child have difficulty holding or playing with toys? | Yes\*\* | No | \*\*If Yes, explain: |
| What does your child like to play with? |  |  | Please describe: |
| Does your child have difficulty playing with others or using pretend play? | Yes\*\* | No | \*\*If Yes, explain: |
| Does your child make eye contact with others? | Yes\*\* | No | \*\*If Yes, explain: |
| Are you concerned about how your child uses crayons/scissors/pencils markers compared with other children of the same age? | Yes\*\* | No | \*\*If Yes, explain: |
| **Occupational Therapy Questions: Self Help** |
| Does your child have trouble getting dressed/undressed? | Yes\*\* | No | \*\*If Yes, explain: |
| Is your child toilet trained? | Yes\*\* | No | \*\*If Yes, explain: |
| Does your child have difficulty sleeping? | Yes\*\* | No | \*\*If Yes, explain: |
| **Occupational Therapy Questions: Sensory Processing** |
| Does your child have difficulty with changes in routine? | Yes\*\* | No | \*\*If Yes, explain: |
| Is your child bothered by loud noises, certain clothing or strong smells? | Yes\*\* | No | \*\*If Yes, explain: |
| Do you find it difficult to calm/soothe your child? | Yes\*\* | No | \*\*If Yes, explain: |
| Is it difficult to take your child to public places like the grocery store, park or library? | Yes\*\* | No | \*\*If Yes, explain: |
| Is it difficult for your child to pay attention at home or in school? | Yes\*\* | No | \*\*If Yes, explain: |

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| **Speech and Language Questions** |
| When was a problem with speech/language first noticed?  |  |  | Age:  |
| Was speech progress ever interrupted or reversed? | Yes | No | Please describe: |
| Did the speech problem follow an illness, accident, or unusual occurrence? | Yes | No | Please explain:  |
| Has the child had a hearing evaluation? | Yes | No | What were the results?  |
| Does your child respond to Soft or moderate sounds?  | Yes | No |  |
| Does the child seem to listen to people’s voices?  | Yes | No |  |
| Does the child like to listen to children’s stories?  | Yes | No |  |
| Can your child follow instructions which are expected for his age?  | Yes | No |  |
| Does your child snore? | Yes | No |  |
| Does your child have frequent ear infections?  | Yes | No |  |
| Is your child understood by family members? | Yes | No |  |
| Is your child understood by others?  | Yes | No |  |
| **Speech and Language Development** **(Please list the age in months when milestone was met)** |
| Pacifier introduced: |  | Pacifier discontinued: |  |
| Sippy cup introduced:  |  | Sippy cup discontinued: |  |
| First word: |  | Put 2 words together: |  |
| Put 3-4 words together:  |  | Speaking in sentences:  |  |
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| How does your child typically communicate:  | Gestures | Single words | Phrases | Sentences |
| Does your child use any other means of communication? | Sign language | PECS or pictures | Speech generating device | Other: |

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| **Feeding** |
| Do you have concerns regarding your child’s eating or feeding?  | Yes | No | Please describe: |
| Do you consider your child to be a picky eater?  | Yes | No | Please explain:  |
| Does your child use utensils at meals? | Yes | No |  |

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| **Vaccination History and Dates received:** |
| **Hepatitis B (HepB)** |  |  | **Varicella (VAR)** |  |
| **Rotavirus (RV)** |  |  | **Hepatitis A (HepA)** |  |
| **Diptheria, Tetanus, & Acelluar perussis** **(DtaP <7 yrs)** |  |  | **Diptheria, Tetanus & Acelluar perussis (Dtap >7 yrs)** |  |
| **Pneumococcal conjugate (PCV13)** |  |  | **Human Papillomavirus (HPV)** |  |
| **Inactivate poliorirus (IPV)** |  |  | **Meningococcal B** **(MenB)** |  |
| **Measles, mumps,rubella (MMR)** |  |  | **Influenza (IIV ro LAIV)** |  |

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| **Medication List** |
| **Start Date** | **Drug** | **Dose** | **Frequency/Route** | **Stop Date** |
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\*Allergies: Please list all:

\*Patient’s Signature: Date:

\*Legal Guardian Signature:

\*Print Guardian’s Name: Therapist initials: