\*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: | |  | | |
|  | | | | | | | | | |
| 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: