Name:_____ DOB: _____

Concerns:

1. What are your current concerns?_____
2. When did you first have concerns about your child?_____
3. What specific skills would you like your child to achieve in therapy?_____

_____

_____

Birth History

1. Age of mother at the time of birth:_____Length of pregnancy:_____

Birth weight:_____Type of delivery:_____vaginal_____Cesarean

2. Pregnancy or delivery complications:_____

_____

_____

3. NICU stay? If yes, how long:_____

_____

Developmental History

1. Please tell the approximate age your child achieved the following developmental milestones (approximately):

played on tummy_____rolled over_____crawled_____sat alone_____
pulled to stand_____ stood alone_____walked alone_____

Medical History

1. Has your child been hospitalizations/reason:_____

2. Please list any medications your child is currently taking:_____

_____

3. Please list any food or drug allergies:_____

4. Has your child had any of the following?

_____adenoidectomy	_____encephalitis	_____seizures
_____allergies	_____head injury	_____sleeping issues
_____breathing difficulty	_____ high fevers	_____tonsillectomy

_____chicken pox	_____measles	_____tonsillitis
_____ear infections	_____mumps	_____torticollis
how many_____	_____rubella	which side _____
_____ear tubes	_____scarlet fever	

5. Diagnosis (if known):_____

6. Has your child ever received, or is currently receiving, any other special services (occupational therapy, speech therapy, specialized physician, special tests, early intervention, imaging): If yes, When & where?_____

_____

_____

7. Does your child have any special equipment?

____Hearing Aids____Glasses____Walkers____Crutches____Brace's____Other:_____

What are your Childs favorite toys &/or interests?_____

_____

_____

School History (if applicable)

1. Grade level:_____

2. Special services received at school: _____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____