Date: _____

IDENTIFYING INFORMATION

Child's Name: _____ Age: _____ Birth Date: _____ Sex: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

_____ _____

Daytime Phone: _____ Daytime Phone: _____

Cell Phone: _____ Cell Phone: _____

E-mail: _____ E-mail: _____

Primary Physician's Name: _____ Physician's Phone: _____

The child lives with: ☐ Birth Parents ☐ Adoptive Parents ☐ Foster Parents

☐ One Parent ☐ Siblings ☐ Parent and Step-parent

☐ Other: _____

REFERRING INFORMATION

Who referred this child? _____

Reason for referral: _____

May we have your permission to thank this person for the referral? ☐ Yes ☐ No

What are <u>your</u> primary concerns and/or goals regarding your child? _____

_____

At what age did you begin to have these concerns? _____

In what settings does your child struggle? (i.e. home, school, store, etc.) _____

In what settings does your child do well? (i.e. home, school, store, etc.) _____

What are your child's strengths? _____

How would you describe your child? _____

_____

_____

MEDICAL HISTORY

Were there any difficulties during the pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

Length of pregnancy: _____ Length of labor: _____

Birth was: ☐ Normal ☐ Caesarian ☐ Breech ☐ Multiples Weight:_____

Did your child experience any of the following complications during infancy?

Required breathing assistance ☐ Yes ☐ No

If yes, please explain: _____

Feeding difficulties ☐ Yes ☐ No

If yes, please explain: _____

Has your child had any of the following?

☐ adenoidectomy
☐ allergies
☐ chicken pox
☐ colds
☐ respiratory/breathing difficulties
☐ sleeping difficulties
☐ high fevers
☐ scarlet fever
☐ cardiac problems
☐ vision problems
☐ tonsillectomy
☐ encephalitis
☐ mumps
☐ flu
☐ sinusitis
☐ head injury
☐ seizures
☐ thumb/finger sucking
☐ measles
☐ meningitis
☐ ear tubes
☐ tonsillitis

☐ ear infections – how often? _____

☐ other surgeries: _____

☐ other hospitalizations: _____

Please check any of the following professionals who have provided services concerning your child.

Area of Service	Clinician	Date	Diagnosis/Recommendations
☐ Occupational Therapists	_____	_____	_____
☐ Physical Therapist	_____	_____	_____
☐ Speech Language Pathologist	_____	_____	_____
☐ Developmental Pediatrician	_____	_____	_____
☐ Vision Specialist	_____	_____	_____
☐ Hearing Specialist	_____	_____	_____
☐ Behavior Specialist	_____	_____	_____
☐ Neurologist	_____	_____	_____
☐ Orthopedist	_____	_____	_____
☐ Psychologist	_____	_____	_____
☐ Counselor	_____	_____	_____
☐ Other: _____	_____	_____	_____

Is your child currently on medication? ☐ Yes ☐ No If yes, please specify:

Name of Medication	Purpose
_____	_____
_____	_____
_____	_____

Please list any previous medications: _____

Does your child have specialized equipment? ☐ Yes ☐ No

If yes, please specify: _____

DEVELOPMENTAL HISTORY

Please check whether your child's skill achievement was "on time," delayed or is not yet mastered. Age ranges for typical development are in parentheses.

MOTOR:	On time	Delayed	Not yet mastered
Head control (3mos.)	☐	☐	☐
Reaching for objects (3 mos.)	☐	☐	☐
Roll over both ways (7-8 mos.)	☐	☐	☐
Finger feeding (7-8 mos.)	☐	☐	☐
Sitting alone (7-9 mos.)	☐	☐	☐
Creeping on all 4's (9 mos.)	☐	☐	☐
Pulling to stand (9 mos.)	☐	☐	☐
Eating with spoon (1-1.5 yrs.)	☐	☐	☐
Walking (1-1.5 yrs.)	☐	☐	☐
Jumping (2-3 yrs.)	☐	☐	☐
Hopping on one foot (3-4 yrs.)	☐	☐	☐
Drawing a circle (3-4 yrs.)	☐	☐	☐
Cutting with knife (5-6 yrs.)	☐	☐	☐
Cutting with scissors (5-6 yrs.)	☐	☐	☐
Riding a bike (5-6 yrs.)	☐	☐	☐

Does your child have difficulty learning new motor skills? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

LANGUAGE:	On time	Delayed	Not yet mastered
Looks/responds when called (6-9 mos.)	☐	☐	☐
Looks in direction that others point (9-12 mos.)	☐	☐	☐
Said first word (1-1.5 yrs.)	☐	☐	☐
Pointing to simple pictures (1-1.5 yrs.)	☐	☐	☐
Following one step commands (1-1.5 yrs.)	☐	☐	☐
Combined words (1.5-2 yrs.)	☐	☐	☐
Following several step commands (1.5-2 yrs.)	☐	☐	☐
Spoke sentences (2-2.5 yrs.)	☐	☐	☐

SELF-HELP:	On time	Delayed	Not yet mastered
Bladder control (3 yrs.)	☐	☐	☐
Bowel control (3 yrs.)	☐	☐	☐
Toileting independently (3-4 yrs.)	☐	☐	☐
Snaps independently (4 yrs.)	☐	☐	☐
Buttons independently (4-5 yrs.)	☐	☐	☐
Zips independently (4-5 yrs.)	☐	☐	☐
Dressing independently (4-5 yrs.)	☐	☐	☐
Brushing teeth (4-5 yrs.)	☐	☐	☐
Tying shoes (5 yrs.)	☐	☐	☐
Brushing/combing hair (6-7 yrs.)	☐	☐	☐
Bathing independently (6-7 yrs.)	☐	☐	☐

BEHAVIOR DURING INFANCY

Please select the characteristics that describe(d) your child as an infant:

	Yes	No	Sometimes		Yes	No	Sometimes
Cried a lot, fussy, irritable	☐	☐	☐	Liked being held	☐	☐	☐
Overly demanding	☐	☐	☐	Resisted being held	☐	☐	☐
Alert	☐	☐	☐	Floppy when held	☐	☐	☐
Quiet	☐	☐	☐	Tense when held	☐	☐	☐
Passive	☐	☐	☐	Good sleep pattern	☐	☐	☐
Active	☐	☐	☐	Irregular sleep pattern	☐	☐	☐

CURRENT BEHAVIOR

Please select the characteristics that describe your child at present:

	Yes	No	Sometimes		Yes	No	Sometimes
Mostly quiet	☐	☐	☐	Clumsy	☐	☐	☐
Overly active	☐	☐	☐	Struggles with separation	☐	☐	☐
Tires easily	☐	☐	☐	Nervous habits/tics	☐	☐	☐
Talks constantly	☐	☐	☐	Falls often	☐	☐	☐
Overly impulsive	☐	☐	☐	Wets bed	☐	☐	☐
Restless	☐	☐	☐	Wets/soils pants	☐	☐	☐
Stubborn	☐	☐	☐	Has poor attention span	☐	☐	☐
Resists change	☐	☐	☐	Frustrated easily	☐	☐	☐
Fights often	☐	☐	☐	Has unusual fears	☐	☐	☐
Usually unhappy	☐	☐	☐	Has frequent temper tantrums	☐	☐	☐
Physically aggressive	☐	☐	☐	Seems anxious	☐	☐	☐

Toward whom? _____

SCHOOL HISTORY

What is your child's hand preference? ☐ Right ☐ Left ☐ Both

What is your child's current school/grade level? _____

What are your child's strengths in school? _____

_____

Is your child having any difficulties in school? ☐ Yes ☐ No

If yes, please explain: _____

Is your child in a special class or receiving any support services? ☐ Yes ☐ No

If yes, please specify: _____

Has your child repeated any grade levels? ☐ Yes ☐ No

If yes, please specify: _____

What does the teacher say about your child? _____

_____

_____