



Date: \_\_\_\_\_

### NEW PATIENT INFORMATION

Child's Name: \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Parents/Guardian Names: \_\_\_\_\_

Child lives with:  Birth Parents  Adoptive Parents  Foster Parents  Other: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone: Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

Cell Phone: Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

Names of siblings and ages: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_ Main streamed? \_\_\_\_\_

Services currently received at school: \_\_\_\_\_

Equipment used at home (i.e. walker, braces, etc. - Month, year purchased): \_\_\_\_\_

Equipment used at school: \_\_\_\_\_

Any difficulties with home, school and community access: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialists: \_\_\_\_\_

Insurance:  Medipass  Medicaid HMO  PPO  Other HMO  Trust  Private Pay

What is your reason/concern for having your child evaluated? \_\_\_\_\_

Types of therapy you are seeking for your child:  Physical Therapy  Occupational Therapy  Speech Therapy

What function(s) would you like your child to be doing in the next 6 months (be specific)? \_\_\_\_\_

## MEDICAL HISTORY

Diagnosis: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Date(s) of Onset: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Has your child had any of the following?  Adenoidectomy  Tonsillectomy  Tonsillitis  Measles  Mumps  
 Chickenpox  Shingles  Meningitis  Encephalitis  Cytomegalovirus  HIV/AIDS  Hydrocephalus - shunt  
 Asthma  Ear tubes: when \_\_\_\_\_  Cochlear implant  Hearing aids  Eye glasses for \_\_\_\_\_

Check any of the following problems your child has suffered from and explain:

	Yes	No	Comments
Seizures? Type and How often? Controlled by medication?			
Latex Allergy? Describe.			
Food Allergies? Describe.			
Other Allergies? Describe			
Colds/flu frequently? How often and how quickly he/she recovers?			
Other respiratory problems? Describe.			
Ear infections; when? Date of last hearing screening?			
Vision problems? Describe. Surgery and date? Date of last screening?			
Reflux? Controlled by medication?			
Other digestive problems? i.e. diarrhea/constipation. Describe.			
Aspiration of foods/liquids? Describe			
Drooling? Controlled by medication?			
Heart problems? Describe.			
Muscle spasms, cramps, tendinitis? Describe.			
Numbness, tingling, nerve damage? Describe			
Scoliosis? Degrees? Last x-ray? Correction surgery and date?			
Hip subluxation? Degrees? Last x- ray? Correction surgery and date?			
Other bone/joint problems? Describe.			

Describe other surgeries or procedures he/she has had (myofascial release, Botox, lobectomy, dorsal rhizotomy, etc) :

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List current medications, supplements and dosages: \_\_\_\_\_

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List other treatments and therapies your child has had and/or is currently receiving and where: \_\_\_\_\_

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### BIRTH HISTORY

Weeks gestation: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Delivery:  Vaginal (normal)  Forceps  Vacuum extraction  C-section

Complications during pregnancy?  Yes  No Describe \_\_\_\_\_

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Complications during delivery?  Yes  No Describe \_\_\_\_\_

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Complications after birth?  Yes  No Describe \_\_\_\_\_

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### FEEDING HISTORY/CURRENT DIET

Breast fed:  Yes  No How long? \_\_\_\_\_ Formula fed:  Yes  No How long? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to solids at \_\_\_\_\_ (age) Cow's milk at \_\_\_\_\_ (age) Has G-tube:  Yes  No

Had a barium swallow study?  Yes  No Date \_\_\_\_\_ Chokes on foods/liquids?  Yes  No

Any eating/drinking restrictions?  Yes  No Describe \_\_\_\_\_

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Any food/texture intolerance?  Yes  No Describe \_\_\_\_\_

Describe child's current diet: \_\_\_\_\_

### DEVELOPMENTAL HISTORY

List the approximate age your child first did the following (if applicable): Roll \_\_\_\_\_ Sit alone \_\_\_\_\_

Crawl \_\_\_\_\_ Stand alone \_\_\_\_\_ Walk alone \_\_\_\_\_ Babble \_\_\_\_\_

Say first words \_\_\_\_\_ Put two words together \_\_\_\_\_ Speak in short sentences \_\_\_\_\_

Drink from sippy cup \_\_\_\_\_ Drink from straw \_\_\_\_\_ Drink from regular cup \_\_\_\_\_

Self-feed \_\_\_\_\_ Toilet train \_\_\_\_\_ Self-bathe \_\_\_\_\_ Brush teeth \_\_\_\_\_ Self-dress \_\_\_\_\_

Button pants/shirt \_\_\_\_\_ Zip/unzip pants \_\_\_\_\_ Tie shoes \_\_\_\_\_

### CURRENT FUNCTIONS/ISSUES

Mark all that currently apply to your child:

#### GROSS MOTOR SKILLS:

Holds head up (specify, how long?) \_\_\_\_\_

Pushes on elbows / extended arms (circle all that apply)

Gets on all-fours (specify how) \_\_\_\_\_

Crawls (specify how) \_\_\_\_\_

Sits supported / alone (circle one, specify how and length) \_\_\_\_\_

Stands up from the floor (Specify how) \_\_\_\_\_

Stands (Specify how and length) \_\_\_\_\_

Walks (distance and equipment used, if any) \_\_\_\_\_

Walks up/down stairs (specify how, support needed) \_\_\_\_\_

Can carry objects while walking (specify) \_\_\_\_\_

Jumping

Can keep up with peers

Protects self using hands when he/she falls

#### FINE MOTOR & SELF-HELP SKILLS:

Hold own bottle, cup

Has difficulty managing personal hygiene

Has difficulty dressing

Has difficulty self-feeding

Crosses midline to reach for object on the other side of the body

Writes legibly

ORAL MOTOR/FEEDING:

- Has difficulty chewing
- Has difficulty moving food with tongue to the sides
- Puts toys/objects in the mouth

COMMUNICATION & COGNITIVE SKILLS:

- Communicates:  Verbal  Word approximations  Sign language  Gestures  Communication cards  Device
- Makes sounds or says words that are difficult to understand
- Understands what you are saying
- Responds when name is called
- Follows simple directions
- Responds correctly to yes/no questions
- Repeats sounds, words or phrases over and over
- Recognizes objects, people, places
- Responds correctly to who/what/where/when/why questions
- Says sentences longer than 4 words under one breath
- Retrieves/points to familiar objects upon request
- Takes some time to respond or act upon request (delayed response)
- Stutters
- Demonstrates appropriate facial expressions (sad, happy, angry, tired, bored)
- Responds appropriately to facial expressions of others
- Has imaginative play
- Has difficulty matching or sorting
- Plays with toys for their intended purpose
- Easily remembers past events
- Has difficulty retaining previously taught concepts
- Has difficulty problem solving relative to age

SENSORY PROCESSING/REGULATION:

- Stumbles or falls frequently
- Appears awkward or less coordinated
- Demonstrates stiff or rigid movement patterns
- Has difficulty figuring out how to move body or takes more time to learn/perform motor tasks
- Has poor sense of body in space, runs into things
- Seeks external support for posture (leans on furniture, wall or people, slouches, holds head)
- Fatigues quickly
- Has difficulty visually attending to an object/person
- Gets easily distracted
- Calms self easily
- Gets angry/frustrated easily
- Gets destructive / aggressive toward others
- Has self-abusive behaviors
- Resists to novice tasks and environments
- Resists certain positions or movements (i.e. upside down, bouncing, swinging)
- Spins things or self
- Has sensitivity to light, sounds/noise
- Initiates hugs/kisses
- Does not tolerate certain textures (clothing, surfaces, foods, toys)(circle all that apply)
- Resists touch
- Avoids getting messy
- Seeks out (craves) touch or movement
- Seeks out (craves) visually stimulating objects
- Seeks out (craves) stimulating sounds
- Allows brushing of teeth
- Bangs on surface, bangs/hits head or uses a lot of pressure when touching someone or holding object
- Flaps hands
- Has difficulty finding objects with competing background (items on a desk, in a room, etc)
- Obsesses with a certain order of things
- Has difficulty transitioning from one activity to another (resists change)
- Has difficulty falling asleep
- Has difficulty remaining asleep through the night
- Appears lethargic / sleepy all the time
- Sleeps a lot

SOCIAL-EMOTIONAL SKILLS:

- Has difficulty making friends
- Plays with other kids
- Only plays with adults
- Prefers to play alone
- Has separation difficulties
- Gets easily frustrated/impulsive
- Has poor eye contact

What activities, toys, games, TV shows, music is your child interested in? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What extracurricular activities is your child involved in (dance, sports)? \_\_\_\_\_

\_\_\_\_\_

Do you currently have a home program that was given by a therapist in the past or that you self-taught to help your

child? If so, describe what you do (i.e. stretching, strengthening activities, brushing, etc): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any adaptive equipment that your child is in need of (i.e. wheelchair, walker, hand splint): \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_