Medical History

Patient Name: _____ Date of Birth: _____

Concerns

Please list the primary concerns that you would like to address with therapy: _____

_____

_____

_____

_____

_____

Pregnancy

Do you know the details of the pregnancy? ☐ Yes ☐ No

Pregnancy Proceeded: ☐ Normally ☐ With Complications

Length of Pregnancy (in weeks): _____ Prenatal care was: ☐ Received ☐ Not Received

Pregnancy Complications:

- ☐ Eclampsia
- ☐ Gestational Diabetes
- ☐ Multiple Births
- ☐ Polyhydramnios
- ☐ Positive for Cytomegalovirus 'CMV'
- ☐ Positive for Herpes
- ☐ Positive for HIV
- ☐ Positive for Strep B
- ☐ Pre-eclampsia
- ☐ Premature Labor
- ☐ Substance Exposure
- ☐ Toxemia
- ☐ Other _____

Please add any other comments regarding pregnancy: _____

_____

_____

_____

Delivery

Do you know the details of the delivery? ☐ Yes ☐ No

Delivery Proceeded: ☐ Normally ☐ With Complications

Delivery was: ☐ Vaginal ☐ C-section ☐ Emergency C-section

Delivery Complications:

- ☐ Abruption Placenta
- ☐ Breech Presentation
- ☐ Low Birth Weight
- ☐ Negative Vacuum
- ☐ Non-progressive/unproductive Labor
- ☐ Occiput Posterior Postion (Face up)
- ☐ Placenta Previa
- ☐ Premature Rupture of Membranes
- ☐ Transverse Presentation
- ☐ Prolapsed Cord
- ☐ Use of Forceps
- ☐ Uterine Rupture
- ☐ Umbilical Cord Wrapped Around Neck
- ☐ Other _____

Birth Information:

Mother's age at time of birth: _____ Birth Hospital: _____

Needed to be transferred to another hospital ☐ Yes ☐ No Transfer Hospital: _____

Birth Weight: _____ Birth Height: _____ Apgar: 1 min _____ 5 min _____ 10 min _____

Please indicate for this pregnancy:

Were there multiple children born from this pregnancy? ☐ Yes ☐ No

Number of live births: _____ Number of still births: _____

Additional details of birth: _____

_____

_____

Following Birth

Were there any complications following birth? ☐ Yes ☐ No

Length of child's hospital stay: _____

Complications Following Birth:

- ☐ Anemia of Prematurity
- ☐ Bronchopulmonary Dysplasia 'BPD'
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Club Foot
- ☐ Cytomegalovirus
- ☐ ECMO
- ☐ Failure to Thrive
- ☐ Hyperbilirubinemia
- ☐ Intrauterine Growth Retardation 'IUGR'
- ☐ IVH Bleed Grade I
- ☐ IVH Bleed Grade II
- ☐ IVH Bleed Grade III
- ☐ IVH Bleed Grade IV
- ☐ Jaundice treated by light therapy &/or blanket
- ☐ Meconium Aspiration
- ☐ Necrotizing Enterocolitis 'NEC'
- ☐ Neonatal hypoxia
- ☐ Oxygen dependency
- ☐ PDA
- ☐ Positive dependency
- ☐ Respiratory Distress Syndrome
- ☐ Respiratory Stridor
- ☐ Respiratory Syncytial Virus 'RSV'
- ☐ Retinopathy of Prematurity 'ROP'
- ☐ Thrombocytopenia (Low Platelet count)
- ☐ Ventilator Dependency
- ☐ VP Shunt
- ☐ Other _____

Please list any other complications or details: _____

_____

Please list any syndromes that have either been diagnosed or are suspected: _____

_____

Current Medications

Does the child currently take any medications? ☐ Yes ☐ No

Name of Medication	Dose	Frequency	Method

Comments: _____

_____

Allergies

Does the child have any allergies? ☐ Yes ☐ No

Please list the child's allergies:

_____

_____

_____

Hearing Test

Do you have concerns about the child's hearing? ☐ Yes ☐ No

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Last Test Date: _____

Results: _____

_____

Concerns: _____

_____

Vision Test

Do you have concerns about the child's vision? ☐ Yes ☐ No

☐ Never Tested, No Concerns

☐ Never Tested, Have Concerns

☐ Normal Test Results

☐ Abnormal Test Results Last Test Date: _____

Results: _____

_____

Concerns: _____

_____

Surgeries

Has the child had any surgeries or procedures? ☐ Yes ☐ No

Surgeries and Procedures	
Type	**Date**

Tests

Has the child had any diagnostic tests? ☐ Yes ☐ No

Diagnostic Tests		
Test	**When**	**Details/Results (if known)**

Physicians

Does the child see a physician regularly? ☐ Yes ☐ No

Current Physicians			
Name	**Specialty**	**Reason**	**Date of last visit**

Medical Conditions

Does the child have any medical conditions? ☐ Yes ☐ No

Does the child have:

- ☐ Allergies
- ☐ Arteriovenous malformation (AVM)
- ☐ Anoxic brain injury
- ☐ Asthma/respiratory breathing problems
- ☐ Autism
- ☐ Baclofen Pump
- ☐ Cerebral Palsy (CP)
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Chronic Ear Infections
- ☐ Colic
- ☐ Constipation
- ☐ Diarrhea
- ☐ Down Syndrome
- ☐ Hip subluxation Degrees? _____
- ☐ Hydrocele
- ☐ Laryngomalacia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Periventricular Lukomalasia
- ☐ Reflux
- ☐ Scoliosis Degrees? _____
- ☐ Seizure Condition
- ☐ Sleep disorder
- ☐ Sleep problems
- ☐ Shunts
- ☐ Torticollis
- ☐ Traumatic brain injury (TBI)
- ☐ Tube Feeding
- ☐ Tubes in ears
- ☐ Vagal Nerve Stimulator
- ☐ None

Please list any other medical conditions: _____

_____

_____

_____

Comments: _____

_____

Motor Development

Do you have concerns about the child's motor development? ☐ Yes ☐ No

Please indicate when the child's ability for each activity approximately began or check unsure or has not begun:

Activity	Began at age (in months):	Unsure	Has not begun
Bringing both hands to mouth			
Buttoning pants/shirt			
Come to sitting from a lying position			
Creeping or crawling alone			
Fully Toilet trained			
Grabbing a toy			
Holding head up alone			
Pulling self to standing position			
Rolling Over			
Self-bathing			
Self dressing			
Sitting alone without support			
Standing unsupported			
Tying shoes			
Walking with support			
Walking unaided			
Zipping/unzipping jacket			

Handwriting:

Is your child: ☐ Right Handed ☐ Left Handed ☐ Neither

Are there concerns about handwriting? ☐ Yes ☐ No

Please describe: _____

Play:

What are the childs favorite toys or play activities? _____

How does the child primarily move around the home? _____

Sensory

Sensory Processing & Regulation (please select all that apply):

- ☐ Avoids getting messy
- ☐ Seeks out (craves) touch or movement
- ☐ Stumbles or falls frequently
- ☐ Appears awkward or less coordinated
- ☐ Flaps hands
- ☐ Resists/does not allow brushing of teeth
- ☐ Bangs on surface, bangs/hits head
- ☐ Fatigues quickly
- ☐ Has self-abusive behaviors
- ☐ Resists certain tasks or environment
- ☐ Spins things or self
- ☐ Is sensitive to lights,sounds or noise
- ☐ Sleeps a lot
- ☐ Resists touch
- ☐ Walks on toes
- ☐ Lines up toys or objects
- ☐ Seeks out (craves) visually stimulating objects
- ☐ Seeks out (craves) stimulating sounds
- ☐ Resists certain movements (e.g. bouncing, swinging, upside down)
- ☐ Has difficulty figuring out how to move body or takes more time with movements
- ☐ Does not tolerate certain textures (e.g. clothing,surfaces,foods)
- ☐ Uses lots of pressure when touching someone or holding object
- ☐ Has difficulty transitioning from one activity to another
- ☐ Has difficulty falling asleep
- ☐ Has difficulty remaining asleep through the night
- ☐ Appears Lethargic/sleepy all the time
- ☐ Has poor sense of body in space, runs into things
- ☐ Seeks support for posture (e.g. leans on furniture, walls or people, holds head)
- ☐ Demonstrates stiff or rigid movement patterns
- ☐ Hyperfocussed (on specific tasks, people, objects, etc.)

Other (please describe): _____

_____

_____

☐ None

Social

Social/Emotional Skills (select all that apply):

- ☐ Is easily distracted
- ☐ Calms self easily
- ☐ Gets angry/frustrated easily
- ☐ Is aggressive towards others
- ☐ Prone to emotional outbursts
- ☐ Doesn't allow others to join in play
- ☐ Has difficulty making friends
- ☐ Plays with peers
- ☐ Only plays with adults
- ☐ Prefers to play alone
- ☐ Has difficulty with separations
- ☐ Has poor eye contact
- ☐ Other: please describe _____

Description of Child (select all that apply):

- ☐ Active
- ☐ Affectionate
- ☐ Aggressive
- ☐ Calm
- ☐ Cautious
- ☐ Curious
- ☐ Demanding
- ☐ Difficult to Comfort
- ☐ Distractible
- ☐ Fearful
- ☐ Fearless
- ☐ Fussy
- ☐ Insecure
- ☐ Motivated
- ☐ Passive
- ☐ Persistent
- ☐ Playful
- ☐ Shy
- ☐ Stubborn
- ☐ Withdrawn
- ☐ Other: _____

Feeding

Do you have concerns about the child's feeding or diet? ☐ Yes ☐ No

Does the child currently use any feeding adaptations? ☐ Yes ☐ No

Feeding Milestones			
When did the child begin?	**Age (in months)**	**Milestone**	**Age (in months)**
Using a Bottle		Using a Straw	
Using a Pacifier		Stop Using a Bottle	
Eating baby food		Stop Using a Pacifier	
Eating table food		Using Utensils to Eat	
Drinking from a Cup		Holding own bottle/cup	
Drinking from a Sippy Cup		Self-feeding	

Breast Feeding

☐ # times currently breast fed per day _____ ☐ Weaned from breast feeding at age: _____

☐ Was never breast fed

Feeding (continued)

Describe Any Feeding Problems: _____

_____

Food Likes: _____

_____

Food Dislikes: _____

_____

Areas of Difficulty

☐ Chewing ☐ Drooling ☐ Transitioning Between Foods ☐ Jaw shifts/slides/juts
☐ Communication Needs ☐ Swallowing ☐ Understanding Words

Current Feeding Adaptations

☐ Thickened Liquids: Consistency: _____
☐ Adapted Utensils Details: _____
☐ Adapted seating Details: _____
☐ Calorie supplements Details: _____
☐ Tube Feeding Amount: _____ Times per day: _____ ☐ Continuous ☐ Bolus

Speech Language

Do you have concerns regarding the child's speech, language or communication skills? ☐ Yes ☐ No

Speech Milestones			
When did the child begin?	**Age (in months)**	**Milestone**	**Age (in months)**
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

What were the child's first words: _____

Communication Skills		
Does the child:	Yes	No
Have speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

Please describe current speech concerns: _____

_____

_____

_____

The child's primary method of communication is: ☐ Verbal ☐ Non-Verbal

Is an augmentative communication device used? ☐ Yes ☐ No

Details: _____

Select the primary methods of verbal communication used:

☐ None
☐ Vocalizations
☐ Single Words
☐ 2 word Phrases
☐ Complete Sentences

Select the primary methods of verbal communication used:

☐ Facial Expressions
☐ Body Language
☐ Manual Sign Language
☐ Gestures
☐ Pointing
☐ Eye Gaze

Home Environment

Child lives with: (Please select all that apply)

- ☐ Birth mother
- ☐ Birth father
- ☐ Adoptive mother
- ☐ Adoptive father
- ☐ Legal guardian
  Please specify: _____
- ☐ Step-mother
- ☐ Step-father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Siblings
  Please list siblings ages: _____
- ☐ Other Relative
  Please specify: _____

Additional Comments: _____

_____

_____

Adoption

Was the child adopted? ☐ Yes ☐ No Age at adoption: _____

Additional Details: _____

Type of Home

- ☐ Single Level
- ☐ 2 Level
- ☐ Other: _____
- ☐ Ground Floor Apartment
- ☐ Upper Level Apartment
- ☐ Assisted Living Facility
- ☐ Skilled Nursing Facility
- ☐ Group Home

Stairs

Are there stairs to get into the home? ☐ Yes ☐ No How many? _____

Handrail? ☐ Right ☐ Left ☐ None

Are there stairs inside the home? ☐ Yes ☐ No How many? _____

Handrail? ☐ Right ☐ Left ☐ None

Is there a Ramp to get into the home? ☐ Yes ☐ No

Where is the Bathroom located?

- ☐ Main Level
- ☐ Upper Level

Where is the Bedroom located?

- ☐ Main Level
- ☐ Upper Level

Additional Comments: _____

_____

_____

Equipment

Does the child use any equipment to assist with activities, mobility or positioning? ☐ Yes ☐ No

Equipment presently used (Please select all that apply):

Equipment	Approx. Age	Details	Uses at Home	Uses at School/Day Care
Braces				
Walker				
Stander				
Manual Wheelchair				
Power Wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splint(s)				
Track System				
Other:				
Other:				
Other:				

Equipment (continued)

Comments: _____

_____

_____

Other Services

Does the child currently receive any services? ☐ Yes ☐ No

Please select all that apply:

Therapy Services	Type	Status	How often?	Where?
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental History				
EI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Therapy				
Speech / Language Therapy				
Developmental Follow-up Clinic				
Other:				

School

Does your child have an IFSP? ☐ Yes ☐ No

Does your child have an IEP from school? ☐ Yes ☐ No

Grade in School: _____ Name of School: _____

Has your child had a psychological or neuropsychological evaluation completed? ☐ Yes ☐ No

Comments: _____

_____

_____

Is the child involved in any community groups or sports activities? ☐ Yes ☐ No

If yes, please provide more details: _____

_____

_____

Home Program

Do you currently perform a home program with the child? (e.g. stretching, strengthening activities, brushing, etc)?

☐ Yes ☐ No

If yes, please describe what you do: _____

_____

_____