Child History Form

General Information

Child's name: ____

Date of Birth: ____________________ Phone: ________________________

Address: ____

City: ______________________________ State: _______ Zip: ____________

Parent /Guardian Name: __________________________________ Occupation: _________________________

Parent /Guardian Name: __________________________________ Occupation: _________________________

Physician: ____ Phone: _______________________

Other Medical Specialist(s):____

____

Referred By: ____

Please write n/a for any item that does not pertain to your child due to their age.

What do you hope to gain from your child's speech therapy, occupational therapy, or physical therapy assessment and/or treatment?____

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____

____

____

Has your child ever received any other evaluations or therapies (past or present)? If so, what type, when and with whom? ____

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____

What are your child's interests? ____

____

____

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____

What are your child's strengths? ____

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____

____

____

Please describe your child's developmental challenges and when you first noticed them. ________________

____

____

____

____

Educational Information

School/Educational program currently attending: ____
Present grade level: ___________________ Special services received in school: ____OT ____ PT ____Speech
Does your child receive any of the following?
____Special Education ____Behavior Intervention ____Other Special Service
Does your child's teacher have concerns with your child's development in any of the following areas?
____ Motor Skills ____ Social Abilities ____ Self-Help Skills ____ Learning Abilities

Prenatal and Birth History

Adopted: ____ Yes ____ No
If so, please list any factors that may have contributed to your child's development. __________________________
____
____
____
Mother's general health during pregnancy (illnesses, accidents, medications, etc.) ____________________________
____
Indicate type of delivery: _____ Head First _____ Feet First _____ Breech _____ Caesarian
Were there any complications during the pregnancy or birth? ____
____
Duration of pregnancy: _____ Full Term _____ Premature _____ If premature, indicate number of weeks: ________

Family History

Siblings	Age
__________________________________	_______________
__________________________________	_______________
__________________________________	_______________

Is there any history in your immediate or extended family of learning problems, motor problems, mental illness, speech or hearing difficulties, or similar difficulties that your child is experiencing? __________________________
____
____
Are there current stresses in the family or child's life? ____
____
____
____
____
If your child was adopted, do you have information about the birth mother's health and pregnancy, or any information about parent family history? ____
____
____

Medical History

Has your child received a medical diagnosis? If yes, please note when and by whom. ___________________________
____
____
____

Check all that apply:
____ Ear infections ____ Trach ____ Glasses
____ Seizures ____ g-tube ____ Heart Condition
____ Asthma ____ Hearing Aids
____ Bowel/Bladder Issues (please specify) ____
____Allergies (Please list) ____
____
____

Other: ____
____
____
____

Does your child have problems in any of the following areas? (Please check)
____ Vision ____ Speech ____ Hearing ____ Balance
Has your child had any surgeries? If yes, what type and when? ____
____
____

Has your child had a vision exam? If yes, what were the results? ____
Has your child had a hearing exam? If yes, what were the results? ____
Is your child currently taking any medications? If so, please list. ____
____
____
____

Developmental History

Did your child enjoy being held from infancy to two years of age? ____
____
____

Was your child difficult to calm as a baby? ____
____
____

Describe your child's typical play skills. Please include information about ages of the people your child plays with; if your child chooses to be a leader, follower, or loner; how many people your child is comfortable playing with at once; and whether your child prefers a few close friends or a lot of acquaintances, etc. ___________________________
____
____
____
____

Describe any difficulties with family routines (e.g. bedtime, bath time, mealtime) ________________________________
____
____
____

To the best of your ability, please indicate the approximate age your child met each developmental milestone:

__________ Roll over
__________ Sat without support
__________ Walked without assistance
__________ Spoke first word
__________ Stopped using bottles
__________ Potty trained
__________ Started dressing self
__________ Buttoned shirt
__________ Crawled
__________ How long did he/she crawl?
__________ Spoke in two word phrases
__________ Fed self with fingers
__________ Fed self with spoon
__________ Dressed self without help
__________ Tied own shoes

Behavior

Please check any of the following that apply to your child:

____ Cries often
____ Frequent temper tantrums
____ Anxious
____ Trouble following directions
____ Trouble with changes in routine
____ Difficulty with transitions
____ Dislikes playground equipment
____ Seems to be "on the go"
____ Poor attention span

Social/Emotional Development

Does your child interact well with others? ____ Yes ____ No
Does your child have trouble making friends? ____ Yes ____ No
Fears, Coping behaviors: ____
____
____
____
____
Does your child have difficulty calming himself/herself when upset? ____ Yes ____ No
Additional comments: ____
____
____
____
____

Sensory History

Please check all that apply:

____ Upset when messy or dirty
____ Crave jumping or movement
____ Sensitive to sound
____ Overly cautious on playground equipment
____ Picky eater
____ Rocks self
____ Difficulty learning new skills
____ Clumsy
____ Mouths objects
____ Dislikes hair brushing
____ Dislikes tooth brushing
____ Sensitive to touch
____ Sensitive to light

Motor Skills

Please indicate which of the following your child is able to do:

____ Hop/balance on one foot
____ Skip
____ Climb on or over object
____ Jump with both feet together
____ Ride a tricycle
____ Ride a bicycle without training wheels
____ Kick a ball
____ Ascend and descend downstairs
____ Color inside the lines
____ Play with manipulative toys
____ Demonstrate a consistent hand preference
____ Identify left and right hands
____ Pump self on a swing
____ Jump rope
____ Throw/catch a ball
____ Cut with scissors

Does your child:

____ Have weak muscles?
____ Have one side stronger than the other?
____ Complain of fatigue when writing?
____ Become easily frustrated when writing?
____ Have difficulty holding a pencil?
____ Reverse letters when writing?
____ Have difficulty with spacing and sizing of letters?
____ Have difficulty copying shapes?
____ Have difficulty remaining on a line when writing?
____ Wear orthotics/braces? Please specify: ____

Describe any current physical limitation not addressed above: ____________________________
____
____

Feeding / Oral Motor

Are there or have there ever been any feeding problems (e.g. problems with sucking, swallowing, choking, drooling, chewing, etc.)? If yes, please describe. ____
____
____
____
____

Have there ever been any concerns with the intake of liquids (e.g. choking, aspiration)? _______________
____
____
____
____

Does your child prefer certain textures (e.g. crunchy, soft, chewy, etc.) or flavors (e.g. salty, sweet, sour, etc.) of food? ____
____
____

What are some of the typical foods in your child's diet? ____
____
____
____
____

Does your child gag when eating certain foods or textures? ____
____
____

Does your child chew on non-food objects? ____

Self Help

Please indicate your child's ability to perform the following skills by placing a check in the appropriate column.

	Independent	With Help	Dependent
Dresses self	___________	_________	__________
Undresses self	___________	_________	__________
Toileting	___________	_________	__________
Brushes teeth	___________	_________	__________
Washes hands	___________	_________	__________
Feeds self	___________	_________	__________
Drinks from an open cup	___________	_________	__________
Zippers	___________	_________	__________
Buttons	___________	_________	__________
Snaps	___________	_________	__________
Puts on socks	___________	_________	__________
Puts on shoes	___________	_________	__________
Ties shoes	___________	_________	__________

Please provide any additional information that may be helpful to your child's therapist: _________________________

____

____

Speech / Language

Primary language spoken at home:____

Additional languages spoken at home:____

Describe any problem with the child's speech/language.____

____

____

How does the child usually communicate (gestures, single words, short phrases, sentences)? ____________________

____

____

Does your child:

_____ Have increased frustration during communicative attempts?
_____ Have decreased interest in social situations by age 24 months?
_____ Have initial consonant deletion?
_____ Have limited sound repertoire?
_____ Have inconsistent sound errors?
_____ Have delayed response time?
_____Have an increased need for repetition for response to commands or questions?
_____Understand and follow simple directions?
_____Recognize pictures of common objects?
_____Respond to sounds?
_____Turn head when name is called?

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

Person completing form: ______________________________ Relationship to child: ___________________________

Signed: ____ Date: ____