Pediatric History Form

Please fill out as much of this form as you can. This gives our therapists a better understanding of who your child is and how to best work with them. Please bring any medical reports you have for our records.

Form completed by: _____ Date completed:_____

Child's name: _____ Date of birth: _____ Age: ____

Main language used at home: _____ Other languages used: _____

How were you referred to our facility? □ Dr. _____ □ Other: _____

Why are you coming for an evaluation? What would you like your child to do better or more independently?

_____

_____

_____

Medical History

□ Biological Child □ Adoption □ Foster Care ||Age of child at adoption/foster placement:____

Additional information: _____

_____

Pregnancy

□Prenatal Exposure to: □ alcohol □ tobacco □ drugs □ other:_____

□Breech

□Other complications: _____

_____

_____

Birth

Name of Hospital: _____ Length of stay:_____

□ Premature (before 37 weeks) □ Post mature (after 42 weeks) || Born at _____ weeks gestational age

□ Vaginal birth □ Difficult labor □ Other:_____

□ C-section || Reason:_____

□ Birth weight: _____ Apgar scores:_____

□ Complications:_____

Neonatal/Infancy

□ NICU stay Hospital:_____ Length of stay: _____

□ Ventilator/Breathing tube

□ Oxygen tube

□ Retinopathy of prematurity

□ Intraventricular Hemorrhage (IVH) || Grade:____

□ Periventricular Leukomalacia (PVL)

□ Difficulty feeding

□ Physical/Occupational Therapy

□ Speech Therapy

□ Reflux/Gastroesophageal Reflux Disease

□ Hearing test || Results: □ Pass □Fail

Current Medical Status

Referring Physician: _____ Phone: _____

Please tell us any other doctors or specialists involved in your child's care:

_____

_____

_____

_____

Please list all medical diagnoses your child has, including allergies:

_____ Age diagnosed: _____

_____ Age diagnosed: _____

_____ Age diagnosed: _____

_____ Age diagnosed: _____

Please list all medications your child takes:

_____ Purpose:_____

_____ Purpose:_____

_____ Purpose:_____

_____ Purpose:_____

Does your child wear glasses or have problems seeing? _____

Has your child had a hearing test? _____ When? _____

Results: _____

Please list any additional hospitalizations since birth:

Age: _____ Reason: _____ Length of stay:_____

Age: _____ Reason: _____ Length of stay:_____

Age: _____ Reason: _____ Length of stay:_____

Has your child had any special tests or procedures? (eg MRI, EEG)

Date:_____ Procedure: _____ Findings: _____

Date:_____ Procedure: _____ Findings: _____

Date:_____ Procedure: _____ Findings: _____

Has your child been previously evaluated or treated by an Occupational Therapist, Physical Therapist, or Speech Language Pathologist? Please describe findings or treatments: _____

_____

_____

Development – Please write at what age your child first performed the following skills, or if they are not independent with these skills, how much help is usually given:

Sat alone: _____ Toilet-trained: _____

Crawled: _____ Learned to write: _____

Walked: _____ Said a single word: _____

Babbled: _____ Dressed Him/Herself: _____

Used a cup: _____ Fed Him/Herself: _____

Does your child use any special equipment at home or at school?

□ Walker □ Wheelchair □ Special cups/spoons

□ Assistive Technology || List:_____ □ Other: _____

□ Infant "walker" or jumper □ Infant Swing □ Exersaucer □ Sippy Cup

Speech and Language – Please list any speech/language difficulties:

_____

_____

_____

Have your child's language skills decreased? (Lost words, no longer follows directions)_____

Feeding- Please list any problems with eating:

_____

_____

_____

Has your child had a swallow study given by a speech pathologist? _____

Findings: _____

School

School: _____ Grade: _____

Teacher(s): _____

Support Services:

□ Individual Family Service Plan (IFSP)

□ Individual Education Plan (IEP)

□ Adaptive Physical Education

□ Physical Therapy

□ Occupational Therapy

□ Assistive Technology

□ Speech Therapy

□ Classroom Aide

□ Other: _____

□ Involved in organized activities or sports? _____

□ Any concerns or difficulties? _____

Behavior

What are your child's favorite activities? _____

What motivates your child? _____

Does your child have any behavior problems? _____

_____

Does your child have any attention problems? _____

Does your child have repetitive behaviors? (eg hand flapping, rocking, lining up toys)Please list:

_____

Is your child bothered by certain sensations/feelings?

□ Noises □ Textures □ Movements □ Lights □ Smells

Please specify: _____

Does your child repeat or echo certain words or phrases? _____

Please add anything else we should know about your child:

_____

_____

_____

_____

_____

_____