Patient Name _____ **Date of Birth** _____

Preferred pronoun: ☐ He ☐ She ☐ They ☐ Them ☐ Other: _____

GENERAL INFORMATION

Person completing this form: ☐ Parent(s) ☐ Guardian ☐ Foster Parent(s):_____

Email address: _____

How did you learn about our program? ☐ Physician ☐ Family ☐ Friend ☐ School ☐ Community Event

Specialists your child sees: _____ Specialty: _____ Phone: _____

_____ Specialty: _____ Phone:_____

Established diagnoses (List): _____

Please describe your reasons for seeking services:

_____

_____

What do you want your child to be able to do that he/she is currently not able to do?

_____

_____

HEALTH INFORMATION

Current medications, alternative medical interventions and/or supplements:

_____ Reason: _____

_____ Reason: _____

Is your child experiencing any pain? ☐ Yes ☐ No If yes, is it: ☐ mild ☐ moderate ☐ severe ☐ Location _____

Please check any conditions that apply to your child's medical history:

☐ Vocal nodules	☐ Asthma	☐ Head injuries / concussion	☐ Glasses
☐ Pneumonia	☐ Frequent colds	☐ Fractures	☐ Swallow study
☐ Ear infections	☐ Meningitis	☐ Hyperactivity	☐ AFO's/braces
☐ Ear tubes	☐ Seizures	☐ Reflux	☐ Weakness
☐ Cerebral hemorrhage	☐ Heart problems	☐ Craniofacial deformities	☐ Snoring
☐ Abnormal voice	☐ Diabetes	☐ Sleep difficulties	☐ Failure to thrive

☐ Other:_____

Please list any surgeries (Including dates and locations): _____

_____

Has your child's hearing been tested in the last 12 months? ☐ Yes–(within normal limits) ☐ Yes–(aid not pass) ☐ No

Patient Name: _____ **Date of Birth:** _____

Please describe any additional medical work-ups that have been completed in the last 6 months:

_____

_____

Please list any special equipment that your child requires (wheelchair, communication device, etc…):

_____

List any allergies: _____

Has your child started experiencing changes associated with puberty? □ Yes □ No

PREGNANCY & BIRTH HISTORY

Please check any conditions that apply to pregnancy and/or birth history:

□ premature □ late □ breech delivery □ cesarean section □ forceps delivery □ required oxygen

□ neonatal intensive care unit □ jaundice □ required a feeding tube

Did/does your child have problems with: □ sucking? □ swallowing? □ drooling? □ breathing? □ other?

If yes, please describe: _____

_____

Birth weight: _____

FEEDING INFORMATION

Current type of diet: □ regular □ liquids □ puree □ chopped □ other: _____

How does your child eat or drink? □ breast-fed □ bottle □ cup □ sippy cup □ spoon/fork □ feeding tube

Does your child cough, gag or have increased congestion during or soon after meals? □ Yes □ No

Do you consider your child's diet to be limited by □ texture □ taste □ temperature

Describe: _____

Does your child eat less than 20 foods? □ Yes □ No

Please describe any concerns related to feeding or swallowing:

_____

Patient Name: _____ **Date of Birth:** _____

MOTOR MILESTONES

Did your child achieve motor milestones as expected? ☐ Yes ☐ No (if no, check all that were delayed)

☐ tummy time greater than 15 min ☐ rolling ☐ sitting independently ☐ on hands and knees ☐ crawling

☐ cruising along furniture ☐ standing independently ☐ walking alone

Please describe motor concerns: _____

_____

Does your child primarily use his /her ☐ right hand? ☐ left hand? ☐ both hands?

Does your child have difficulty with any of the following: ☐ using utensils? ☐ tying shoes?

☐ holding a crayon or pencil? ☐ cutting with scissors? ☐ writing? ☐ using fasteners on clothes?

SELF HELP SKILLS

Does your child dress / undress independently? ☐ Yes ☐ No If no, what help does he/she need?

_____

_____

Does your child have difficulty with toileting activities (i.e.: clothing management, voiding, wiping)? ☐ No ☐ Yes

If yes, please describe: _____ _____

How does your child sleep? ☐ restful ☐ difficulty falling asleep ☐ restless ☐ nightmares ☐ wakes early

Does your child have difficulty completing grooming and/or hygiene activities (i.e.: hand/face washing, brushing hair, nail clipping, etc.)? ☐ No ☐ Yes Describe: _____

BEHAVIORAL INFORMATION

What activities does your child enjoy? (toys, puzzles, sports, games, characters, etc.)

_____

Describe any behavioral challenges exhibited by your child: _____

_____

Does your child seek out any of the following? (Check all that apply)

☐ rocking ☐ twirling ☐ jumping ☐ spinning ☐ biting ☐ repetitive activities ☐ head-banging ☐ crashing

Does your child appear: ☐ insensitive to pain? ☐ clumsy? ☐ distractible? ☐ aggressive?

Patient Name: _____ **Date of Birth:** _____

EDUCATIONAL INFORMATION

What school/childcare does your child currently attend? _____ Grade _____

If daycare or preschool program, list days and times child attends: _____

Did/does your child receive additional support services? (check all that apply)

□ Early Intervention □ Special Education □ 504 plan □ Educational Aide □ OT, PT, Speech

□ Community-based services □ Family supports/services □ Behavioral interventions □ Counseling

Other: _____ _____

How does your child learn best? (check all that apply) □ hearing □ seeing □ doing

What is your child's readiness to learn and interact with others? □ excellent □ good □ fair □ poor

FAMILY INFORMATION

Caregiver Occupation(s): _____ _____

List the people now living in the household:

Name	Relationship to Child	Age

Parent / Guardian Signature: _____ Date _____

To be filled out by Rehabilitation Services

- ☐ I have verified, within the scope of my interview and assessment of the patient, that he/she is not experiencing difficulties related to sexual, physical or emotional abuse or neglect in the home.
- ☐ Therapist suspects there may be an identified abuse issue. Follow procedures outlined in (PE) policies in the Administrative Policy Manual

Therapist reviewing patient history Signature: _____ Date / Time: _____