CONTACT INFORMATION

Child's Name: _____ ***Date of Birth*** *(DOB)*: _____ ☐ Male ☐ Female

Diagnosis (if applicable): _____ *Language(s) Spoken in the Home:* _____

Primary Contact: _____

Address: _____

City, State, Zip: _____

Phone:_____ ☐ Cell ☐ Home ☐ Work ☐

Email Address: _____

Emergency Contact Name: _____ *Phone number:* _____

Relationship to Child: _____

INSURANCE INFORMATION

Insurance Provider (Aetna, BCBS, United Healthcare, etc): _____ **Is this Sooner Care?** ☐Yes ☐No

Member ID: _____ **Group Number:** _____

Name of Policy Holder: _____ **Relationship to Child:** _____

Pediatrician & Name of Clinic: _____ / _____

Other Physicians / Specialists Involved In Care (if any):

Name: _____ _____ *Phone Number:* _____ *(* *)* _____

Name: _____ _____ *Phone Number:* _____ *(* *)* _____

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FAMILY BACKGROUND

Parent 1 *Name:* _____ *Age:* _____

Occupation: _____*Marital Status:* _____

Parent 2 *Name:* _____ *Age:* _____

Occupation: _____*Marital Status:* _____

Who else lives in the home with the child?

Name	*Age/Gender*	*Name*	*Age/Gender*
1.		*3.*	
2.		*4.*	

MEDICAL HISTORY

Perinatal Health:

What was the mother's age at time of delivery? _____*Were there any complications during pregnancy?* ☐Yes ☐No

If yes, describe: _____

Was there any excessive stress during the pregnancy? ☐Yes ☐No

If yes, describe: _____

Were there any complications during labor or delivery? ☐Yes ☐No

If yes, describe: _____

Child's Health:

At how many weeks gestation was the child born? _____ *weeks (40 weeks is typical)*

How much did the child weigh? _____

How was the child delivered? ☐ Naturally (vaginally) ☐ Cesarean Section

Please describe any complications or concerns during labor or delivery: _____

_____

_____

Did the child remain in NICU for any duration? ☐Yes ☐No

If yes, describe: _____

Describe any additional pertinent information about the child's medical history (surgeries, diagnoses, chronic illnesses, etc.)

Medication:

***Please list any of the child's current medications**:*

Medication Name	***Dosage***	***Reason***

Please list and describe any known allergies: _____

Does the child have a history of ear infections. ☐Yes ☐No

Has the child had ear tubes? ☐Yes ☐No. *If yes, list approximate date.*_____

Does the child have any known hearing loss? ☐Yes ☐No

Is the child receiving any additional services such as: OT PT ABA Counseling (circle all that apply)

DEVELOPMENTAL HISTORY

Please give your closest approximation at what age your child:

Motor Milestone:	***Age Achieved***
Held head up	
Rolled over	
Reached actively for an object	
Sat unsupported	
Crawled	
Stood alone	
Walked unaided	
Ran unaided	
Toilet trained	
Feeds self	

Language Milestone:	***Age Achieved***
Responded to "no"	
Followed 1-step directions	
Recognized/ responded to own name	
Babbled ("bababa" "mamama" etc)	
Used gestures (waving, pointing, shaking head, etc)	
Uses sounds in the back of the throat (ex. "g" or "k")	
Said first word	
Responds appropriately to Yes/ No Questions	
Follows 2-step directions	
Put two words together	
Uses simple sentences	
Responds appropriately to "What" and "Where" Questions	

If under 4 years of age, about how many words does your child say:

☐0-20 ☐21-50 ☐51-100 ☐101-150 ☐151-300 ☐301-500 ☐501+

Does your child put words together to form phrases or sentences? ("Mommy go!", "I want more" etc)

About what percentage of your child's speech do you understand? _____%
How well do people outside of the family understand their speech? _____%

Describe your child's primary form of communication (e.x: no attempt to communicate, gestures, single words, sentences, conversation, etc) _____

_____

SOCIAL HISTORY

How does the child interacts with other children: _____

_____

What are the child's favorite games/ activities?: _____

_____

What are your child's strengths? _____

_____

What are the child's weaknesses? _____

_____

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? _____

_____

Describe any significant events or changes within the home(ex. Moving, divorce, etc.): _____

_____

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SENSORY

Is/ does your child…

Sensitive to textures (avoids/ seeks certain textures)	☐ Yes	☐ No
Sensitive to sounds (avoids certain sounds)	☐ Yes	☐ No
Make excessive noises	☐ Yes	☐ No
Sensitive to light(s)	☐ Yes	☐ No
Clumsy or accident prone	☐ Yes	☐ No
Constantly moving (running, wiggling, fidgeting, etc)	☐ Yes	☐ No
Have difficulty attending to tasks or sustaining tasks	☐ Yes	☐ No
Over-focus on a task making it difficult to get his/her attention	☐ Yes	☐ No
Have difficulty transitioning to new activities	☐ Yes	☐ No
Have difficulty transitioning to new locations	☐ Yes	☐ No
Tolerate new people well	☐ Yes	☐ No
Tolerate playgrounds	☐ Yes	☐ No
Tolerate other children	☐ Yes	☐ No
Share toys/ activities well	☐ Yes	☐ No
Become frustrated easily	☐ Yes	☐ No
Actively play with other children	☐ Yes	☐ No
Use two fingers to pick up small objects	☐ Yes	☐ No
Aggressive with self or others	☐ Yes	☐ No
Drool	☐ Yes	☐ No
Excessively mouth objects	☐ Yes	☐ No
Picky eater	☐ Yes	☐ No
Have any intense fears (list: _____ _)	☐ Yes	☐ No
Other: _____	☐ Yes	☐ No

FAMILY GOALS

Will the family be available to participate in therapy and/ or home program to facilitate the child's progress?

☐ Yes ☐ No

How often are you available for therapy? _____

How often would you like for your child to receive therapy? _____

Please List ALL availabilities with an asterisk (*) next to your preferred therapy times. (Note: We cannot guarantee these times but will make every attempt to work within your preferred availability)

MON:	***WED:***	***FRI:***
TUE:	***THUR:***	***SAT:*** ----------

Please describe several of your goals for the child or family over the next 6 months.

a. _____
b. _____
c. _____
d. _____

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