Professional Therapy Services, Inc.

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"Playing To Succeed!"

Name:_____ Birth Date:_____

Age:_____ Sex:_____ SSN of Insured Party:_____

Address:_____

City:_____ State:_____ Zip:_____

In Case of Emergency, please contact:_____Relationship:_____

work:_____home:_____cell:_____

Mother/Guardian Name:_____ Birth Date:_____

Phone Number - work:_____home:_____cell:_____

Father/Guardian Name:_____ Birth Date:_____

Phone Number - work:_____home:_____cell:_____

Name of Additional Caregivers: _____

Phone Number - work:_____home:_____cell:_____

Who referred you for assessment?_____

Child's Current Pediatrician:_____

I. Medical History:

A. Prenatal & Birth

1. General health during pregnancy (illnesses, accidents or infections?) & length of pregnancy: _____
2. Birth Weight:_____ Delivery: ☐ Normal ☐ Breech ☐Caesarian
3. Were there any complications, such as:
   ☐ Difficulty breathing ☐ Congenital defects ☐ Blue color at birth _____
   ☐ Limpness ☐ Jaundice ☐ Other:_____
4. Was there a need for:
   ☐ Oxygen ☐Transfusions ☐Respirator ☐Tube feedings
5. Were there any feeding difficulties? (If so, please describe)_____
6. Did the child have problems sucking, swallowing or breathing?_____
7. Was the child's length of stay in the hospital unusually long? (If so, please describe)_____
   _____

B. Illnesses (Please check all that apply; If applicable, please give date):
   ☐ Colds ☐ CMV ☐ RSV ☐ Asthma ☐ Seizures/Convulsions
   ☐ Ear Infections ☐ Parent's history of drug/alcohol abuse ☐Other:_____

Allergies (If so, please specify) _____

Injuries or Surgeries (if so, please explain) _____

1. Are immunizations up to date? ☐Yes ☐No (if no, please explain)_____
2. Please list date of child's last physical examination:_____Doctor:_____
3. Has your child had a hearing evaluation? ☐Yes ☐No Results:_____
   By whom:_____Date:_____
4. Has your child had an eye evaluation? ☐Yes ☐No Results:_____
   By whom:_____Date:_____
5. Has your child ever required hospitalization or surgery? (If so, please describe nature and date)
   _____
6. Please describe any serious injuries or accidents:_____
   _____
7. Is your child currently on any medications? (Please list & state reason, if applicable):_____
   _____
8. Past/Present services used to address problem areas:_____
   _____

II. Developmental History:

A. Please give approximate age when child first:

Rolled over(stomach to back)____ (back to stomach)____ Sat without support____

Crawled____ Walked alone____ Toilet Trained_____ Said first word _____

Sucked thumb (how long did he/she suck thumb?)____

Used pacifier (how long was it used?)____

B. Does your child have any of the following:

☐ Sleeping problems ☐ Feeding problems ☐ Tires more easily than peers

☐ Difficulty drawing ☐Pick up & hold objects readily ☐ Fall/lose balance easy

☐Difficulty grasping objects ☐Difficulty dressing ☐ Appear awkward/uncoordinated

☐ Sensitivities to being touched ☐ Sensitivities to clothing textures

☐ Difficulties keeping hands to self ☐ Difficulty choosing hand dominance(age 5 & older)

☐ Difficulty learning new activities involving large movements of the body

☐ Tend to avoid large movements during play (ex. Rough & tumble play)

☐ Difficulty changing activities ☐ Difficulty attending to activities

III. General Behavior

A. Please check all characteristics that apply to your child:

☐ Friendly ☐ Shy ☐ Hyperactive ☐Angry ☐Nervous ☐Stubborn

☐ Sucks Thumb ☐ Plays Alone ☐ Wets bed ☐ Throws Tantrums

☐ Plays primarily with Older/Younger Children

1. How does he/she get along with other children? _____ Adults? _____
2. Does your child prefer to play alone or with others?_____
3. Do you think your child is able to participate with a structured, standardized assessment lasting:

   ☐15 minutes ☐30 minutes ☐60 minutes ☐not able to participate
4. Do you have concerns about your child's behavior? Please describe. _____

   _____
5. Is your child ever aggressive with others?_____

IV. Educational/Family Background:

1. Please list any day care centers/schools that your child has attended.

   (Please include Grade Level, City & State):_____

   _____

2. Does he/she have any specific problems in school or services? _____
3. Has anyone on either side of the family had speech, learning or motor problems? (If so, please list relationship to child & problem)_____

_____

V. Comments:

If there are any factors that you feel would help in evaluating your child that are not covered in this form, please describe below. Use a separate sheet if necessary. Thank you.

_____

_____

_____

_____

_____

_____

_____

Parent Signature: _____

Relationship to Child:_____

Date Completed: _____

For Speech Therapy Evaluation – Skip to Section VI

For Occupational Therapy Evaluation – Skip to Section VII

For Physical Therapy Evaluation – Skip to Section VIII

VI. Speech/Language:

A. Early

1. At what age did your child combine words into small sentences? Ex. "Want drink" or "Me out" _____
2. At what age did your child use more complete sentences? Ex. "I want a drink" or "Let me go out" _____
3. At what age did he/she "coo" or babble? _____
4. At what age did he/she use words meaningfully? Name people & objects? _____

B. Speech Intelligibility:

Easily understood by all _____ Understood by family _____

Not completely understood _____ Other _____

Communicates through gestures only _____

C. Does your child:

1. Express him/herself as well as others his/her age? _____
2. Understand as well as others his/her age? _____
3. Remember what is said to him/her as well as others his/her age? _____
4. Follow instructions as well as others his/her age? _____
5. Describe your child's early reactions to sound: _____
6. Was his/her early speech easy to understand? _____
7. Have difficulty swallowing/eating particular foods or eating a variety of foods? _____
8. Stutter or repeat sounds, words or phrases? _____
9. Become "hoarse" or have other voice problems? _____
10. Use his/her speech seldom, frequently or never? _____
11. Problem seem worse at certain times than others? Please explain: _____
12. Seem aware of the problem? _____
13. Understand/hear a second language at home? _____

VII. Motor & Sensory – Occupational

Occupational therapy is therapy based on engagement in meaningful activities of daily life. The primary goals of childhood are to grow, learn and play. For children and youth, occupations are activities that enable them to learn and develop life skills (ex. school activities), be creative (ex. play) and thrive (ex. self-care & care for others).

Occupational therapists address the areas of fine motor skills, self-help skills, sensory integration and attention/regulation to support children in becoming as independent as possible at home, school and in the community.

1. What are your primary concerns regarding your child? _____

_____

2. What community activities does your child participate in? _____

_____

3. Name of physicians/specialists following the child?_____

_____

4. Diagnosis, dates of diagnosis and diagnosing physician if applicable:_____

_____

A. Sensory (if applicable):
   1. Are you familiar with sensory integration? If so, please explain._____

      _____

   2. What are you hoping to gain from a sensory integration evaluation?_____

      _____

B. Fine Motor Skills/Handwriting:
   1. Do you have any concerns regarding your child's ability to manipulate small objects? Please explain._____

   2. Do you have any concerns regarding your child's handwriting? Please explain._____

      _____

***If Handwriting is a concern, please bring a sample of your child's independent work.**

3. Does your child:
   ☐ snip with scissors ☐ cut straight lines ☐cut curved lines ☐cut simple shapes

C. Self-Help Skills

1. Can your child perform the following skills independently?
   ☐ snap ☐button ☐ zip ☐ dress independently without fasteners
   ☐ toileting ☐ bathing ☐ brush teeth ☐ brush/comb hair
   ☐ manage spoon ☐ manage fork ☐ manage knife
   ☐ drink from cup(s), type(s): _____
   ☐ If your child has any feeding challenges, please describe: _____
   _____
   ☐ Special diet: _____ ☐ Food allergies: _____
   ☐ Preferred foods: _____ ☐ Food aversions: _____
2. Please list areas that you would like to see your child gain more independence: _____
   _____
3. Is there any additional information/concerns that will be beneficial to the Occupational Therapy evaluation? _____
   _____

VIII. Physical Therapy

Physical therapy services are designed to reduce pain and improve or restore mobility, in many cases without expensive surgery and often reducing the need for long-term use of prescription medications and their side effects.

Physical therapy helps individuals needing to restore or improve activities necessary of daily life due to illness, injury, disease, disorder, condition, impairment disability, activity limitation or participation restriction.

1. Height & Weight of Child:_____
2. As a parent, what are your primary concerns?_____
3. Has your child ever had Physical Therapy? If so, for what reasons & how was your/their experience? ____

_____

4. How long of a therapy session could your child tolerate? ☐ 30 min ☐ 45 min ☐ 1 hour
5. Are there any fears that your child experiences that the therapist should avoid during functional play?
   ☐ No ☐ Yes – please explain: _____
6. Does your child:
   - ☐ Complain of pain? *If yes, please refer to Chart A*
   - ☐ Complain of pain at night that wakes them up?
   - ☐ Complain of dizziness, vertigo or the room spinning after a positional change?
   - ☐ Fall frequently? If so, please explain:_____
   - ☐ Bruise easily?
   - ☐ Bleed profusely when a scrape/cut occurs?
   - ☐ Walk in the following manner (please circle all that apply):

Tip toe. Toes in. Toes out. Flat/heavy footed. In a clumsy manner. Does not walk at all.

7. Is your child:
   - ☐ Able to pay attention to their environment, avoiding hazards 75% of the time?
   - ☐ Able to stand on 1 foot for more than 10 seconds?
   - ☐ Able to jump? If so, how high/far: _____
   - ☐ Able to walk up stairs without using a handrail? If no, please explain how they traverse stairs:

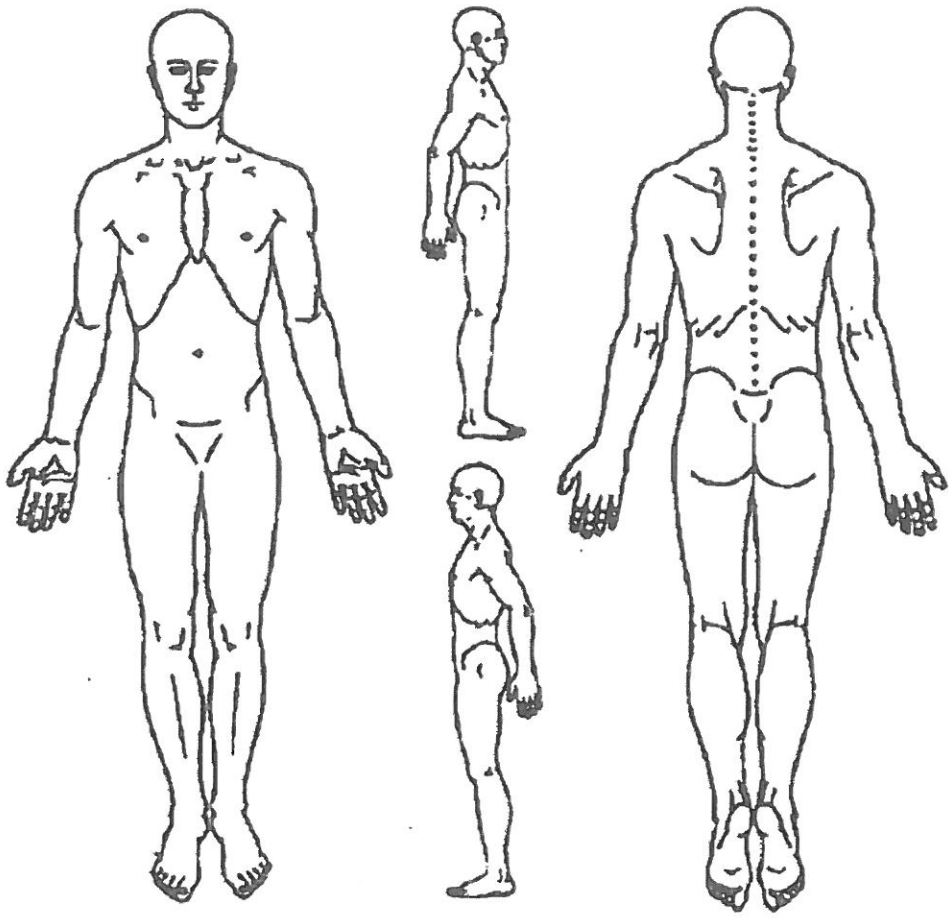
     _____
   - ☐ Able to throw a ball 10 feet both underhanded and overhanded?
   - ☐ Able to catch a ball without closing their eyes and turning their head?
8. Please list any hospitalizations, broken bones, torn ligaments, sprains, strains or other medical emergencies. _____

Chart A

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	O O O O O	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗



NAME _____ DATE _____

No Pain |—————————————————————————————| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature