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Today's Date: _____
Name: _____ Date of Birth: _____
Person completing form: _____

Relationship to patient: ◉ Parent/Guardian ○ Other-_____

Referred by: _____
Name of Physician and location: _____

Reason for evaluation and caregiver concerns:

_____
_____
_____

List any specific goals you hope your child will achieve through therapy:

_____
_____
_____

Please tell us about your child's strengths and accomplishments:

_____
_____
_____
_____
_____

What does your child enjoy?

Activities _____
Toys _____
Movies/TV Shows _____
Community Activities _____
Foods _____

How does your child best learn?

Visual	Auditory	Verbal	Physical	Logical	Social	Solitary	Experiential
☐	☐	☐	☐	☐	☐	☐	☐

Current communication: ◉ Verbal/sentence level ○ Verbal/few words ○ Vocalizing ○ Gesturing ○ ASL

Current diet: ☐ Regular ☐ Cut up foods ☐ Baby Food stage_____ ☐ other_____

Clinician's notes: _____
_____
_____
_____

Pregnancy History: ◯ Full Term ◯ Premature_____weeks

Please list any drug, alcohol or medication use during pregnancy: _____

_____

_____

Please describe any illness/hospitalization of mother during pregnancy: _____

_____

_____

Birth History:

Delivery: ◯ Vaginal delivery ◯ Caesarean delivery		Why?
Was the child one of a multiple birth?	No	Birth Weight:
Was anesthesia/medication given?	No	What kind?
Did the baby go home with the mother?	No	How long after?

		How Long?
Complications/Treatments	No	
Cord around neck?	No	
Breathing Problems?	No	
Transfusions?	No	
Phototherapy?	No	
Difficulty feeding?	No	

Please list any other information regarding prenatal or birth experience:

_____

_____

_____

Medical History: Does the child have any of the following (past or present):

ADD/ADHD	☐ YES	☐ NO	Cerebral Palsy	☐ YES	☐ NO
Allergies	☐ YES	☐ NO	Learning Disability	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Heart Problems	☐ YES	☐ NO
Chicken Pox	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Ear Infections	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO
Gastric	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO
Reflux	☐ YES	☐ NO	Respiratory Disease	☐ YES	☐ NO
Hearing Loss	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Vision Impairment	☐ YES	☐ NO	Pneumonia/Bronchitis	☐ YES	☐ NO
Developmental Delays	☐ YES	☐ NO	Tracheostomy Tube	☐ YES	☐ NO
Tympanostomy Tube (Ear Tubes)	☐ YES	☐ NO	Lingual/Labial Frenectomy	☐ YES	☐ NO
Feeding Tube (N-G, G-tube, G-J)	☐ YES	☐ NO	Nissen	☐ YES	☐ NO
Dietary Restrictions/Special Diets	☐ YES	☐ NO	Feeding Difficulties	☐ YES	☐ NO

Please list any other medical history including specialists, surgeries, medications, supplements, allergies:

_____

_____

_____

Clinician's notes: _____

_____

_____

_____

	Date of Most Recent Visit	Reason for Visit	Outcome
Primary Care			
Audiology			
Vision			
Dental			

Specialized Equipment

☐ Glasses ☐ Hearing Aid ☐ Cochlear Implant ☐ Splints ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Orthotics
☐ Other: _____

Development: ☐ Normal Development for head control (3-4 months), sitting (6-7 months), walking (12-15 months), toilet training (2½-3½ years), & eating ☐ babbling (3-6 months), first words (12-16 months), & combining words phrases/sentences (2-3 years)

☐ Delayed or Later Development (Complete All Below)

Age achieved/further information

Babble:
Caught a thrown object:
Combine two to three words:
Counted to 5:
Crawled on hands and knees:
Cut paper with scissors:
Followed simple one-step directions:
Held head up:
Labeled Colors:
Meaningful Words:
Pedaled a bicycle:
Pedaled a tricycle:
Ran
Recited Alphabet:
Rolled over:
Scribbled with a crayon:
Smiled:
Stood alone:
Threw objects actively:
Trained for bladder/bowel:
Unsupported sitting:
Used Simple Questions:
Walking without holding on:
Does he/she have any accidents?
Does child drool?
Does child have difficulty chewing?
Does child have difficulty sucking?
Does child "W" sit?

Clinician's notes: _____
_____
_____
_____

Has your child received:

		Name/Location/Phone number of therapist	Frequency of treatment
Physical Therapy	No		
Occupational Therapy	No		
Speech-Language Therapy	No		
Behavioral Health Therapy	No		
Feeding Therapy	No		
ABA Therapy	No		
Play Therapy	No		

What was the focus and outcome of each therapy: _____

_____

_____

_____

_____

Self-Care Skills: Please note that this information is only used for treatment planning and to track progress. Your child may not be able to perform some of the tasks due to age or developmental level. Please answer as accurately as possible for your child's behavior *most of the time*.

Action	Dependent (caregiver does majority or all of the task for the child)	Partial Assist (child does majority of task but requires minimal help)	Verbal Assist (child does majority of task but requires verbal guidance)	Independent (child performs 100% of the task)	Unable/Refuses
Shirt on	◯	◯	◯	◯	◯
Shirt off	◯	◯	◯	◯	◯
Pullover on	◯	◯	◯	◯	◯
Pullover off	◯	◯	◯	◯	◯
Pants on	◯	◯	◯	◯	◯
Pants off	◯	◯	◯	◯	◯
Shoes on	◯	◯	◯	◯	◯
Shoes off	◯	◯	◯	◯	◯
Jacket on	◯	◯	◯	◯	◯
Jacket off	◯	◯	◯	◯	◯
Tie shoes	◯	◯	◯	◯	◯
Untie shoes	◯	◯	◯	◯	◯
Zips	◯	◯	◯	◯	◯
Snaps	◯	◯	◯	◯	◯
Unsnaps	◯	◯	◯	◯	◯
Buttons	◯	◯	◯	◯	◯
Unbuttons	◯	◯	◯	◯	◯
Dresses in timely manner	◯	◯	◯	◯	◯
Toilets self	◯	◯	◯	◯	◯

Clinician's notes: _____

_____

_____

_____

Washes hands	◯	◯	◯	◯	◯
Chews	◯	◯	◯	◯	◯
Swallows	◯	◯	◯	◯	◯
Eats a variety of foods	◯	◯	◯	◯	◯
Knife skills- Cuts	◯	◯	◯	◯	◯
Knife skills- Spreads	◯	◯	◯	◯	◯
Opens containers	◯	◯	◯	◯	◯
Closes containers	◯	◯	◯	◯	◯
Brushes teeth	◯	◯	◯	◯	◯
Bathes	◯	◯	◯	◯	◯
Showers (if over 6)	◯	◯	◯	◯	◯

General Behaviors

How is your child's ability to perform the following?

	Great	Good	Fair	Poor	n/a
Follows directions	◯	◯	◯	◯	◯
Interacts with siblings	◯	◯	◯	◯	◯
Interacts with peers	◯	◯	◯	◯	◯
Expresses emotions	◯	◯	◯	◯	◯
Calms self	◯	◯	◯	◯	◯
Entertains self	◯	◯	◯	◯	◯
Accepts "no"	◯	◯	◯	◯	◯
Tolerates changes	◯	◯	◯	◯	◯
Sleeps	◯	◯	◯	◯	◯

Please elaborate on any of these where your child demonstrates difficulty:

_____

_____

_____

Family and Social History:

List any brother/sisters and ages? _____

Who lives in the home? _____

Marital status of parents? ◯ Married ◯ Separated ◯ Divorced ◯ Other

Has anyone in your family had?

			Relationship to Child	Explanation:
ADD/ADHD	No			
Trouble speaking clearly	No			
Hearing impairment	No			
Learning disability	No			
Genetic disorder	No			
Cleft lip/ cleft palate	No			
Autism	No			
Developmental Delay	No			
Other	No			

Clinician's notes: _____

_____

_____

_____

Family stressors: The events that occur within a family can impact a child, please indicate if any of the following have happened within the past 12 months. Please elaborate as you feel comfortable.

		Details
Marital status	Yes	
Death in the family	No	
Financial related	No	
Job related	Yes	
School related (bullying, educational, new school)	No	
Legal	No	
Medical related	No	
Moved	No	
Extended separation from primary family members	No	
New sibling	No	
Household composition	No	

Educational History: ☐ No School ☐ Preschool ☐ Elementary School ☐ Homeschooled ☐ Early Intervention School
name/telephone number:_____

How many days per week? ◯ 1 ◯ 2 ◯ 3 ◉ 4 ◯ 5 ☐ Half day ☐ Full day

Grade:_____ Teacher's Name:_____

Does your child have any concerns with attention, communication, mobility or learning at school?

_____
_____
_____
_____

Does your child have a current IEP or 504 ◯ YES ◯ NO
Please describe any special tutoring/therapy/accommodations/modifications received in school:

_____
_____
_____
_____

Any other information that you feel would be important for us to know:

_____
_____
_____
_____

Clinician's notes: _____
_____
_____
_____