

434 Hayward Ave. N Oakdale, MN 55128 651-739-2300 651-739-2302 fax

CHILD HISTORY FORM

Today's Date:

The information you provide us with will help us develop a sense of who your child is and how you, as a parent, experience your child. This helps us to know more about what we need to ask you as well as helps us develop appropriate assessment and intervention plans, as necessary. Thank you for taking the time to be thorough!

Child's Name:

Date of Birth:	Age:		School District:	
School:	Teacher:			
Grade:	School Spe	School Speech Therapist/OT Names:		
Languages spoken in the home:	1			
Reason for contacting our office: (What				
Current Diagnoses (of any kind) and if e	ducational or medically dete	ermined:		
Assessment or Intervention History (Occupational Therapy, Speech Therapy, Physical Therapy, Vision Therapy, psychological). Please provide pertinent reports.				
Is your child on an IEP, IIIP, or IFSP? If yes, please provide a copy of their most recent IEP/IFSP.				
Describe any allergies or food sensitivit	ies:			
List all medications your child currently takes:				
Name:	Dosage / Frequency:		Purpose:	

Describe any prenatal complications and birth complications (Pre-terms, breach, c-section, forceps, low apgar score, jaundice, NICU etc.):				
Delivery Type: Vaginal C-section Forceps				
What was your child's birth weight? Lbs. ounces				
Describe any feeding difficulties currently or during infancy. For example, avoidance of certain textures, drooling, difficulties with swallowing, chewing, or sucking.				
Indicate whether your child has met the following milestones, and at what age they first displayed each skill.				
Roll over from stomach to back and back to stomach:				
Sit independently:				
Crawl: Did they skip crawling?: Did they crawl on 4-points (hands/knees):				
Walk:				
Speak his/her first word: What was it:				
Combine words:				
Speak sentences:				
Drink from a cup independently:				
Toilet trained:				
Toilet trained through the night:				
Feed self with a spoon independently:				
Dress self independently:				
Difficulty with Bathing: (doesn't tolerate?)				
Sleep Difficulties currently: Getting to sleep: Staying asleep: What helps?:				
Hand dominance/preference (left or right): Do they switch?:				
List any infancy or early childhood concerns your pediatrician may have noted. For example, torticollis, hypo or hypertonia.				
Check any that apply:				
☐ Seems clumsy (awkward, flops in seat, poor posture, etc.)				
□ Falls often				
☐ Tires easily				
□ Walks on toes				
□ "W" sits				
□ Poor ball skills				
☐ Appears weaker than peers				
☐ Has difficulty learning new motor tasks				

List any significant childhood illnesses, surgeries or injuries:					
Does your child have a history of frequent ear aches or ear infect	tions? Describe:				
Does your crima have a history of frequent car dones of carca.	itolis: Describe.				
Does your child have a history of PE tubes in his or her ears? Des	cribe age of placement(s) and current status:				
Does your child have a history of PE tubes in his or her ears? Describe age of placement(s) and current status:					
Describe the results of your child's last hearing screening or test:	:				
,					
Has your child had his/her vision tested? If so, describe the concerns and result:					
That you call a had his her tested. It so, describe the concerns and result.					
Where was this completed: (at school, or eye dr.)					
Ol I atheterals					
	neck any that apply:				
	Rubs eyes frequently				
	Eyes tired at the end of the day Eyes tired at the end of the day				
	Complains of eyestrain or headaches				
☐ Trouble copying from board					
☐ Holds things close to eyes					
Makes reversals when writing, copying or reading					
Does your child use any adaptive or home therapy equipment? Describe:					
	1 Construction to such account Academia				
Describe your child related to sensory needs, unusual sensory redodors, or level of stimulation:	sponses, and sensory detensiveness to toucn, sound, texture,				
Describe your child's emotional and behavioral attributes:					
Ol I albahanala					
Check any that apply:	To the control of the				
☐ Is mostly quiet	☐ Is usually happy				
□ Is overly active	☐ Fights frequently				
☐ Talks constantly	☐ Has difficulty separating from primary caretaker				
☐ Impulsive	☐ Is easily frustrated				
□ Is restless	☐ Has unusual fears				
☐ Is stubborn	□ Rocks self frequently				
□ Over reacts	☐ Has frequent temper tantrums. Describe:				
□ Is resistant to change	☐ Has nervous tics or habits. Describe:				
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Describe what your child likes to do and what their strengths are:					

Describe what your child dislikes:		
Describe your child's ability to understand what is said to him/her AND how your child expresses his/her wants, needs, and		
ideas:		
Charles and that any live		
Check any that apply:		
☐ Has difficulty sequencing information		
☐ Has difficulty following directions		
☐ Has difficulty learning new tasks		
Describe how your child interacts socially with family, peers, and adults:		
Check any that apply:		
☐ Plays with toys differently from other children his or her age. Describe:		
☐ Knows and talks about special interests at length, to the exclusion of other topics, and without regard to the listener.		
Describe:		
☐ Has difficulty understanding nonverbal communication (facial expressions, gestures, physical space, tone of voice) or		
seems unaware of those communication cues.		
Does anyone in your family have a history of speech, language, or learning difficulties? Describe:		
Is there a family history of related physical or emotional diagnoses? Describe:		
Describe your goals for your child.		
I would like to see my child be able to		
Speech and Language therapy examples: "talk clearly, use more words, follow directions." Occupational therapy examples: "dress independently, tolerate more sensory experiences, use his/her hands better."		
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Thank you for your time and attention to this information!