



Check which of the following specialists your child has seen/is seeing:

<u>Specialty</u>	<u>Name of agency/specialist</u>	<u>Approximate Date of Last Visit</u>
Cardiologist	_____	_____
Neurologist	_____	_____
Orthopedist	_____	_____
Psychologist/ Psychiatrist	_____	_____
Ophthalmologist/ Optometrist	_____	_____
Speech Pathologist	_____	_____
Occupational Therapist	_____	_____
Physical Therapist	_____	_____
Audiologist	_____	_____
Gastroenterologist	_____	_____
ENT	_____	_____
Other	_____	_____

What are your primary concerns about child: \_\_\_\_\_

\_\_\_\_\_

What are the school's primary concerns: \_\_\_\_\_

\_\_\_\_\_

Has your child been diagnosed as having any medical or educational condition? If so, what?

\_\_\_\_\_



If so, explain: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

Pregnancy – Full term \_\_\_\_\_ Premature \_\_\_\_\_

Mother's general health during pregnancy: good \_\_\_\_\_ fair \_\_\_\_\_ poor \_\_\_\_\_. Problems encountered during pregnancy (illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.) \_\_\_\_\_

\_\_\_\_\_

Medications taken during pregnancy (please specify) \_\_\_\_\_

\_\_\_\_\_

Problems encountered during labor \_\_\_\_\_

Delivery Complications – Induced birth \_\_\_\_\_ breech presentation \_\_\_\_\_

Cesarean section \_\_\_\_\_ forceps delivery \_\_\_\_\_ Elaborate on above delivery

complications and note any others not included: \_\_\_\_\_

\_\_\_\_\_

Birth – Child's birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Complications – Jaundice \_\_\_\_\_ cyanosis \_\_\_\_\_ congenital defects \_\_\_\_\_ limpness \_\_\_\_\_ stiffness \_\_\_\_\_

Elaborate on above complications at birth and note any others not included: \_\_\_\_\_

\_\_\_\_\_

Was there a need for: oxygen \_\_\_\_\_ transfusions \_\_\_\_\_ tube feedings \_\_\_\_\_ ventilator \_\_\_\_\_

If so, explain:

\_\_\_\_\_

Are there feeding problems now? Yes No Explain: \_\_\_\_\_

Hospitalized? If so, how long: \_\_\_\_\_

Problems encountered during child's first month: \_\_\_\_\_

\_\_\_\_\_

Child's general health at present: good \_\_\_\_\_ fair \_\_\_\_\_ poor \_\_\_\_\_

Any present medications? yes \_\_\_\_\_ no \_\_\_\_\_ if yes, type: \_\_\_\_\_

For: \_\_\_\_\_ Any physical handicaps? yes \_\_\_\_\_ no \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Any allergies? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, type: \_\_\_\_\_

Food allergies: \_\_\_\_\_

Any ear infections? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, frequency: \_\_\_\_\_

Tubes? yes \_\_\_\_\_ no \_\_\_\_\_ when: \_\_\_\_\_

Any draining ears? yes \_\_\_\_\_ no \_\_\_\_\_ if yes, how were these treated? \_\_\_\_\_

List significant illnesses/diseases child has had:

Illness: \_\_\_\_\_ age at that time: \_\_\_\_\_

Illness: \_\_\_\_\_ age at that time: \_\_\_\_\_

List any injuries child has had:

Injury: \_\_\_\_\_ age: \_\_\_\_\_

Injury: \_\_\_\_\_ age: \_\_\_\_\_

List surgeries child has had:

surgery \_\_\_\_\_ age \_\_\_\_\_

surgery \_\_\_\_\_ age \_\_\_\_\_

Has child had convulsions/seizures? Age \_\_\_\_\_ type \_\_\_\_\_

Frequency \_\_\_\_\_ medication \_\_\_\_\_

### **DEVELOPMENTAL HISTORY**

Check any of the following that describes your child as an infant:

\_\_\_\_\_ Fussy, irritable

\_\_\_\_\_ Quiet

\_\_\_\_\_ Active

\_\_\_\_\_ Resisted being held

\_\_\_\_\_ Tense muscles when being held

\_\_\_\_\_ Irregular sleep patterns

\_\_\_\_\_ Good, non-demanding

\_\_\_\_\_ Passive

\_\_\_\_\_ Liked being held

\_\_\_\_\_ Floppy when held

\_\_\_\_\_ Good sleep patterns

\_\_\_\_\_ Over active, never still unless sleeping

Comments:

Check any of the following that describes your child at present:

\_\_\_\_\_ Mostly quiet

\_\_\_\_\_ Tires easily

\_\_\_\_\_ Too impulsive

\_\_\_\_\_ Stubborn

\_\_\_\_\_ Overreacts

\_\_\_\_\_ Usually happy

\_\_\_\_\_ Clumsy

\_\_\_\_\_ Has difficulty separating from primary caretaker

\_\_\_\_\_ Falls often

\_\_\_\_\_ Poor attention span

\_\_\_\_\_ Cries often

\_\_\_\_\_ Rocks self frequently

Client History – page 6

<input type="checkbox"/> Overly active	<input type="checkbox"/> Exhibits frequent temper tantrums	<input type="checkbox"/> Cries infrequently
<input type="checkbox"/> Talks constantly	<input type="checkbox"/> Has nervous habits or tics	<input type="checkbox"/> Has difficulty learning new tasks
<input type="checkbox"/> Restless	<input type="checkbox"/> Wets bed	
<input type="checkbox"/> Resistant to changes	<input type="checkbox"/> Easily frustrated	
<input type="checkbox"/> Fights frequently		

Give approximate ages at which child did the following routinely:

<input type="checkbox"/> Held up head	<input type="checkbox"/> Crawled on hands and knees
<input type="checkbox"/> Rolled Over	<input type="checkbox"/> Pulled to standing
<input type="checkbox"/> Sat alone	<input type="checkbox"/> Stood alone
<input type="checkbox"/> Belly crawled (while on stomach)	<input type="checkbox"/> Walked

General impression of child's motor development:

Gross motor: slow \_\_\_\_\_ normal \_\_\_\_\_ advanced \_\_\_\_\_

Fine motor: slow \_\_\_\_\_ normal \_\_\_\_\_ advanced \_\_\_\_\_

Poor handwriting: yes \_\_\_\_\_ no \_\_\_\_\_

Any discrepancies in your impressions versus the school's: yes \_\_\_\_\_ no \_\_\_\_\_

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Self-care:

Currently Bottle fed? yes \_\_\_\_\_ no \_\_\_\_\_ type of formula \_\_\_\_\_

Currently Nursed? yes \_\_\_\_\_ no \_\_\_\_\_ How often? \_\_\_\_\_

Problems with either? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Currently eats:

<input type="checkbox"/> Breastmilk	<input type="checkbox"/> Formula	<input type="checkbox"/> Baby food
<input type="checkbox"/> Junior foods	<input type="checkbox"/> Mashed table food	<input type="checkbox"/> Table foods

Objects to certain foods (texture, taste, etc.) List most common: \_\_\_\_\_  
\_\_\_\_\_

Describe degree to which child routinely performs the following:

Feeds self: all \_\_\_\_\_ most \_\_\_\_\_ some \_\_\_\_\_ rare \_\_\_\_\_ (if feeds self, uses: bottle \_\_\_\_\_  
fingers \_\_\_\_\_ spoon \_\_\_\_\_ fork \_\_\_\_\_)

Client History – page 7

Bathes self: all \_\_\_\_\_ most \_\_\_\_\_ some \_\_\_\_\_ none \_\_\_\_\_

Undresses self: all \_\_\_\_\_ most \_\_\_\_\_ some \_\_\_\_\_ none \_\_\_\_\_

Is child toilet trained? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, at what age? \_\_\_\_\_

Bladder (daytime) \_\_\_\_\_ bladder (day & nighttime) \_\_\_\_\_ bowel \_\_\_\_\_

Has child achieved skills and then lost them? \_\_\_\_\_ If so, what and when: \_\_\_\_\_

---

### SENSORY HISTORY

Vestibular (movement and gravity information). Check which of the following apply to your child:

- |   |   |
|---|---|
| <input type="checkbox"/> Rocks while sitting            | <input type="checkbox"/> Jumps a lot  |
| <input type="checkbox"/> Likes being tossed in the air  | <input type="checkbox"/> Good balance   |
| <input type="checkbox"/> Fearful of heights             | <input type="checkbox"/> Fearful of movement                                    |
| <input type="checkbox"/> Likes merry-go-rounds          | <input type="checkbox"/> Spin & whirl more than other children                  |
| <input type="checkbox"/> Gets car sick                  | <input type="checkbox"/> Prefers more quiet play as opposed to more active play |
| <input type="checkbox"/> No fear of movement or falling |   |

Comments:

Tactile (touch information). Check which of the following apply to your child:

- |  |  |
|--|--|
| <input type="checkbox"/> Avoids "messy" things (mud, finger paint, etc.) | <input type="checkbox"/> Dislikes having face washed or wiped          |
| <input type="checkbox"/> Irritated by cloth or certain textures          | <input type="checkbox"/> Objects to being touched                      |
| <input type="checkbox"/> Dislikes unexpected touch                       | <input type="checkbox"/> Dislikes being cuddled                        |
| <input type="checkbox"/> Prefers to touch rather than be touched         | <input type="checkbox"/> Avoids using hands for extended periods       |
| <input type="checkbox"/> Bangs head on purpose (now or in the past)      | <input type="checkbox"/> Examines objects by putting them into mouth   |
| <input type="checkbox"/> Pinch, bite or otherwise hurt others            | <input type="checkbox"/> Strong likes or dislikes toward food textures |
| <input type="checkbox"/> Tends to feel pain less than others             | <input type="checkbox"/> Dislikes nail cutting                         |
| <input type="checkbox"/> Isolates him/herself from other children        | <input type="checkbox"/> Seeks lots of touch                           |
| <input type="checkbox"/> Excessively ticklish                            |  |
| <input type="checkbox"/> Dislikes hair washing                           |  |
| <input type="checkbox"/> Wants to handle everything                      |  |

Comments:

Proprioceptive (muscle and joint information). Check which of the following apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Holds hands in strange positions               | <input type="checkbox"/> Good coordination with small things (i.e. pencil, buttons) |
| <input type="checkbox"/> Walks on toes (or did when younger)            | <input type="checkbox"/> Went from sitting to standing with little or no crawling   |
| <input type="checkbox"/> Crept on tummy rather than hands or knees      |   |
| <input type="checkbox"/> Leaps from one position to the next, unable to |   |

move slowly from one to another

Comments:

Auditory: Check which of the following apply to your child:

- |   |   |
|---|---|
| <input type="checkbox"/> Responds negatively to unexpected or loud noises | <input type="checkbox"/> Has difficulty paying attention when there are other noises nearby |
| <input type="checkbox"/> Misses hearing some sounds                       | <input type="checkbox"/> Seems to enjoy strange noises and/or make loud noises              |
| <input type="checkbox"/> Seems confused as to the direction of sounds     | <input type="checkbox"/> Has a diagnosed hearing loss                                       |
| <input type="checkbox"/> Appears to be hard of hearing                    |   |
| <input type="checkbox"/> Enjoys music                                     |   |
| <input type="checkbox"/> Wears a hearing aid                              |   |

Comments:

Visual: Check which apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Reversals in copying   | <input type="checkbox"/> Happier in the dark                                  |
| <input type="checkbox"/> Look very closely and carefully at pictures or objects         | <input type="checkbox"/> Has difficulty discriminating shapes or colors       |
| <input type="checkbox"/> Becomes very excited when there is a variety of visual objects | <input type="checkbox"/> Resists having eyes covered                          |
| <input type="checkbox"/> Has difficulty focusing on things close                        | <input type="checkbox"/> Has difficulty visually focusing on things far away  |
| <input type="checkbox"/> Has difficulty maintaining eye contact with another person     | <input type="checkbox"/> Wears glasses  |
| <input type="checkbox"/> Sometimes shakes head in awkward manner                        | <input type="checkbox"/> Difficulty following an object tossed toward him/her |
| <input type="checkbox"/> Shifts head to one side in order to look at an object          |   |

Comments:

Gustatory-Olfactory (taste and smell information). Check which of the following apply to your child:

- |  |   |
|--|---|
| <input type="checkbox"/> Acts as though all food tastes the same | <input type="checkbox"/> Chews on non-food objects              |
| <input type="checkbox"/> Dislikes foods of certain textures      | <input type="checkbox"/> Has unusual cravings for certain foods |
| <input type="checkbox"/> Discriminates between odors             | <input type="checkbox"/> Explores by smelling                   |
| <input type="checkbox"/> Ignores unpleasant odors                | <input type="checkbox"/> Reacts negatively to smell             |

Comments:

### **SPEECH/LANGUAGE HISTORY**

Give approximate ages at which child did the following:

babbled \_\_\_\_\_ said first word \_\_\_\_\_ What were first words? \_\_\_\_\_

combined two words \_\_\_\_\_ give example \_\_\_\_\_

used 3-4 word sentences \_\_\_\_\_ give example \_\_\_\_\_

obeyed simple commands \_\_\_\_\_

Check those which describe your child’s ability to use spoken language: (If applicable)

- |   |   |
|---|---|
| <input type="checkbox"/> Makes no sound or on a very limited basis                        | <input type="checkbox"/> Language is limited to gestures                      |
| <input type="checkbox"/> No true words  | <input type="checkbox"/> Language is limited to single words or short phrases |
| <input type="checkbox"/> Uses simple sentences  | <input type="checkbox"/> Repeats words often or hesitates frequently          |
| <input type="checkbox"/> Sentences are long but disorganized and hard to understand       | <input type="checkbox"/> Words are difficult to understand                    |
| <input type="checkbox"/> Voice quality is unusual (hoarse, nasal or earthy, high pitched) | <input type="checkbox"/> Has difficulty recalling recent events               |
| <input type="checkbox"/> Has no apparent problems expressing himself                      | <input type="checkbox"/> Has trouble remembering the correct names of things  |
| <input type="checkbox"/> Stutters frequently  | <input type="checkbox"/> Seems frustrated at trying to relate events          |

Check those which apply to your child’s listening habits:

- |  |  |
|--|--|
| <input type="checkbox"/> Responds only to loud sounds    | <input type="checkbox"/> Seems to ignore people when they are talking to him/her |
| <input type="checkbox"/> Responds as if sound is painful | <input type="checkbox"/> Seems uninterested                                      |
| <input type="checkbox"/> Seems to hear properly          |  |

Check which statements best describe your child’s ability to understand language:

- |   |   |
|---|---|
| <input type="checkbox"/> Understands no spoken language   | <input type="checkbox"/> Understands a few words                        |
| <input type="checkbox"/> Follows simple commands          | <input type="checkbox"/> Understands most words                         |
| <input type="checkbox"/> Understands simple conversations | <input type="checkbox"/> Understands everything that is said to him/her |

At present, how much of your child’s speech can be understood?

- |                          |           |            |            |            |
|--------------------------|-----------|------------|------------|------------|
| By mother:               | all _____ | most _____ | some _____ | none _____ |
| By other family members: | all _____ | most _____ | some _____ | none _____ |
| By neighbors:            | all _____ | most _____ | some _____ | none _____ |

If applicable, describe your child’s speech problem (give examples):

If applicable, how severe to you think problem is? severe \_\_\_\_\_ moderate \_\_\_\_\_ mild \_\_\_\_\_

Is your child aware of the problem? \_\_\_\_\_ How does he/she react? \_\_\_\_\_

Is any language other than English used in the home? \_\_\_\_\_ If yes, what language \_\_\_\_\_

what percent of the time? \_\_\_\_\_

**SCHOOL INFORMATION**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Grades repeated? \_\_\_\_\_ Skipped? \_\_\_\_\_

Has child been in a special classroom and/or attended any remedial classes? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe what type, where, when? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you or the teacher observed that your child is:

1. Noticeably distracted in class? \_\_\_\_\_

2. Functions better in a one-to-one relationship than in classroom situations? \_\_\_\_\_

3. Has to be reminded how to hold his pencil/paper when writing? \_\_\_\_\_

4. Needs to prop head in his/her hand while reading or writing at the desk? \_\_\_\_\_

5. Shows a hand preference? \_\_\_\_\_ Which hand does he/she prefer for feeding? \_\_\_\_\_

crayon or pencil \_\_\_\_\_ throwing \_\_\_\_\_ pointing \_\_\_\_\_ cutting \_\_\_\_\_

If he/she prefers the left hand, are there other left-handers in the family? \_\_\_\_\_

6. Confused in right-left discrimination tasks? \_\_\_\_\_

7. A poor speller? \_\_\_\_\_

8. A poor reader? \_\_\_\_\_

9. Good at making friends easily? \_\_\_\_\_

10. Tends to prefer to play with younger children? \_\_\_\_\_

11. Tends to prefer the company of adults \_\_\_\_\_

12. A loner? \_\_\_\_\_

13. What academic skills are the hardest? \_\_\_\_\_

If there are other concerns not covered by this form, please share those with us.