Rehabilitation Services

Pediatric Speech Or Physical Therapy Medical/Developmental History

Child's Name: ________________________ Nickname:____________ Today's Date:__________

Name of Guardians:____________________________ Person Completing Form:_____________

Guardian's DOB:____________ Referred by:____

Reason for Referral:____

Child's Identifying Information

Sex: M / F Birth Date:___________Age:_______ Telephone Number: (_____)____________

Address:___________________________________ City:_______________________ State:____

Zip:________________ Child's Social Security #: ______________________________________

With whom does the child live: (please check all that apply)
Mother ______ Father _______
Siblings______ (How many:______, List ages:______________)
Grandparents_____
Foster Care______ (How long has child been in your care?_____________)
Others:____

Parent's employment: ____
Circle those that apply: Full Time Part Time Retired Homemaker Unemployed Student Disability Other:___________________________
If full time or part time, what are your hours?____

Medical History

How would you rate your child's health? (please circle)

EXCELLENT GOOD FAIR POOR

Medical History: Please check if your child has ever had any of the following:

____Heart Problems	____Allergies
____Kidney Problems	____Lung Problems
____Head Injury	____Ventilation Tubes
____Feeding Tube	____Hearing Loss
____Diabetes	____Seizures
____Stomach Problems	____Aspiration Pneumonia
____Reflux (GERD)	____Anxiety
____Sensory Problems	____ADD or ADHD

____Autism, Aspergers, or PDD-NOS
____Ear Infections (How Many:_____ Describe Treatment: __________________________)
____Developmental Delay (Areas of Delay:____)

Has your child ever had surgery? YES NO
If yes, please list the type of surgery with the dates (month/year if known):

____
____
____

Medications:
Please list the medications your child is currently taking:________________________________

____
____

Allergies: (Please list)
Is your child allergic to any medications? YES NO ____
Does your child have a latex allergy? YES NO ____
Does your child have any other allergies? ____

____

Is your child on any kind of special diet or do they have any food restrictions?

____
____

Developmental History

Pregnancy and Birth:

Length of pregnancy:____________ Age of mother at birth:__________________

Describe any unusual conditions during pregnancy:___________________________________

____

Duration of labor: ______________ Were instruments used:____________________________

Anesthesia used, list type:____

Describe any unusual conditions at or immediately after birth (feeding, swallowing, breathing, etc…)____

____

Did your child spend time in the NICU: YES NO if yes, how long:________________________

At what age did your child first…:

Physical Skills:

__________Roll __________Sit Unassisted __________Crawl

__________Stand __________Walk __________Climb Stairs

Please describe any concerns with physical skills (uncoordinated, falls…etc)_______________

____

Feeding:

________Take solid foods ________Drink from a cup ________Finger feed

________Use utensils ________Wean from bottle ________Use straw

Please describe any concerns with feeding (picky eater, gagging, swallowing trouble…etc)___

____

____

Self Care:

________Wash hands ________Undress ________Dress

________Comb hair ________Brush teeth ________Tie shoes

________Button ________Bladder trained ________Bowel trained

Please describe any concerns with self care skills:______________________________________

____

Communication:

________Babble ________Respond to name ________Gesture/Point

________Imitate speech ________Spoke 1st word ________Use signs (ASL)

________Use two word sentences

Did your child start talking and then stop: YES NO If yes, what age:_____________________

Please check all that describe your child's communication:

___Use wrong words ___Frustrated when not understood
___Unable to follow directions ___Unable to get words out
___Talks too fast ___Talks too slow
___Unable to relay information ___Uses only gestures to communicate
___Does not ask questions ___Repeats certain sounds or words over and over again
___Talks too loudly ___Starts and stops and starts speech again
___Talks to softly ___Gets stuck on certain sounds or words
___Produces sounds incorrectly ___Unable to understand child's speech
___Appears to ignore others ___Doesn't respond to his/her name
___Non-verbal

If your child is non-verbal how do they communicate?___________________________________
____

My child is understandable to (circle): Parents Grandparents Siblings Teachers Strangers

I feel that my child talks like other children his or her age: YES NO

Please describe any concerns with speech (if your child has a limited vocabulary or is not using many words, please list the words they do use):___________________________________
____
____
____
____
____

Hearing:

Does your child have a diagnosed hearing loss? YES NO

If yes, when was it diagnosed: _________________ By whom:___________________________

Does your child wear hearing aids? Left ear: YES NO Right ear: YES NO

Has your child ever had his/her hearing evaluated or screened? YES NO

My child complains of : Dizziness___ Ringing/Noise in ears___ Loud sounds___

Please describe any concerns with hearing:____
____

Social Skills:

Does your child separate easily from parents? YES NO If no, please explain:______________
____

Does your child play well alone? YES NO If yes, for how long?__________________________

Does your child play well with others? YES NO If yes, doing what and for how long?_______
____

What are your child's favorite toys and/or play activities?________________________________

____

Where is your child during the day?____

If school aged, Where does your child attend school?_____________________________

____

What grade is your child in at school?____

Does your child receive school therapy services? YES NO

Who are your child's teachers and therapists in the school setting?___________________

____

What hours/days does your child attend school?_________________________________

____

Behavior/Discipline:

Please check all that describe your child:

___Overactive	___Aggressive	___Fearful
___Withdrawn	___Restless	___Poor self esteem
___Temper tantrum	___Cries easily	___Outgoing
___Destructive	___Unhappy	___Shy
___Difficult to discipline	___Happy	___No fears

Does your child have any unusual behaviors or concerns?__________________________

____

What is the most effective way to discipline your child?___________________________

____

What do you do to reinforce your child for doing something good?___________________

____

Does your child receive behavioral therapy? YES NO_______________________________

Does your child currently receive any other therapy services? YES NO

Has your child previously received any other therapy services? YES NO

If yes, please list where services are provided (or have been previously) as well as the therapist and the frequency:____

____

____

If your child is here for summer services, would you like to continue beyond summer? YES NO

Additional Comments:

Please provide any additional information about your child that you would like to share:____

____

____

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