Patient Name: _____ Date of Birth: _____ Date of Eval: _____

SUBJECTIVE

Evaluations Performed Today: ☐ PT (Physical Therapy) ☐ OT (Occupational Therapy) ☐ ST (Speech Therapy)

Why are you seeking treatment for your child? _____

_____

_____

Has your child had any prior treatment and/or diagnostic testing for this condition? □ Yes □ No

If Yes: □ X-rays □ MRI □ EMG/Nerve Conduction Test □ Vision □ Hearing Is the child aware of problem? □ Yes □ No

If yes, how does the child feel about the problem? _____

Other: _____

If yes, please explain: _____

_____ Date of next Doctor's appointment: _____

Other healthcare professionals who provide care:

Provider Name: _____ Type of Specialist: _____ City: _____ State: _____

Provider Name: _____ Type of Specialist: _____ City: _____ State: _____

Provider Name: _____ Type of Specialist: _____ City: _____ State: _____

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below

Subjective History: _____

_____

_____

_____

_____

_____

_____

CURRENT COMPLAINTS

What are your main concerns regarding your child?

□ Fine Motor (i.e., handwriting, buttoning) □ Mobility □ Feeding □ Behavior □ Other: _____

□ Gross Motor (i.e., walking, kicking a ball □ Articulation □ Language □ Sensory Processing □ Other: _____

THERAPIST USE ONLY: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below

Other Related Information: _____

_____

PREGNANCY AND BIRTH HISTORY

Were there any complications during pregnancy? □ Yes □ No Comments: _____

Mother's age at the time of birth: _____ Birth Hospital: _____

Please check ALL that apply:

□ Eclampsia □ Pre-eclampsia □ Gestational Diabetes □ Multiple Births □ Polyhydramnios □ Positive for Cytomegalovirus (CMV)

□ Positive for Herpes □ Positive for HIV □ Positive for Strep B □ Premature Labor □ Toxemia □ Other

Was the pregnancy full term? □ Yes □ No Comments: _____

Were any drugs or medications taken during pregnancy? □ Yes □ No Comments: _____

Was labor and delivery normal? □ Yes □ No Comments: _____

Were there complications following birth? □ Yes □ No Comments: _____

Birth weight: _____ pounds _____ ounces Hearing Test Normal? □ Yes □ No Comments: _____

Please check ALL that apply:

□ Anemia or Prematurity □ Bronchopulmonary Dysplasia (DPD) □ Club Foot □ Cytomegalovirus □ ECMO □ Jaundice
□ Hyperbilirubinemia □ Intrauterine Growth Retardation (IUGR) □ IVH Bleed Grade_____ □ Meconium Aspiration
□ Necrotizing Enterocolitis (NEC) □ Neonatal Hypoxia □ Oxygen dependency □ PDA □ Positive dependency
□ VP Shunt □ Respiratory Distress Syndrome □ Retinopathy of Prematurity (ROP) □ Thrombocytopenia (low platelet count)
□ Ventilator Dependency □ Other_____

Patient Name: _____ Date of Birth: _____ Date of Eval: _____

GROWTH AND DEVELOPMENT

At what age did your child: (Began at Age in months)

□ Roll over from stomach to back? _____ □ Roll over from back to stomach? _____ □ Hold head up alone?_____

□ Sit Independently? _____□ Crawl? _____ □ Bring both hands to mouth? _____

□ Walk holding onto furniture? _____ □ Walk independently? _____ □ Grab a toy? _____

□ Speak first word? _____ □ Speak in 2 word sentences? _____ □ Bathe self? _____

□ Drink from cup? _____ □ Use a spoon? _____ □ Toilet train? _____

□ Dress independently? _____□ Button pants/shirt? _____ □ Hold a crayon or pencil? _____

□ Zip/unzip a jacket - At what age did your child zip_____

Please describe your child:

□ Mostly Quiet	**□ Tires Easily**	**□ Talks Constantly**	**□ Clumsy**	**□ Happy**
□ Impulsive	**□ Overly Active**	**□ Overreacts Frequently**	**□ Shy**	**□ Restless**
□ Craves Touch	**□ Laughs Easily**	**□ Gets Frustrated Easily**	**□ Stubborn**	**□ Has Temper Tantrums**
□ Difficulty Separating	**□ Has Nervous Habits**	**□ Has Unusual Fears**	**□ Avoids Touch**	**□ Has Poor Attention Span**
□ Difficult to manage	**□ Aggressive**	**□ Cries Easily**	**□ Eating Problems**	**□ Prefers to Play Alone Sleeping**
□ Toilet training problems	**□ Difficulty Learning New Tasks problems**		**□ Other_____**	

***THERAPIST USE ONLY*: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below**

Other Related Information: _____

_____

_____

PREVIOUS MEDICAL HISTORY/ PRECAUTIONS/CONTRAINDICATIONS

How would you classify your child's general health? □ Good □ Fair □ Poor

Please check ALL that apply:

□ Allergies (i.e., latex, tape, food, other) _____	□ Encephalitis	□ Genetic Disorder	□ Rheumatic Fever
□ Enlarged Glands	□ Nausea/Vomiting	□ Ringing of the Ears	□ Fever
□ Bronchitis	□ Head Injury	□ Hearing Problems	□ Sinusitis
□ Cancer	□ Headaches	□ Mastoidectomy	□ Failure to Thrive
□ Anoxia	□ Heart Disease	□ Muscle Disorder	□ Stroke/TIA
□ Chicken Pox	□ Cerebral Palsy	□ Nerve Disorder	□ Surgeries
□ Chronic Colds	□ Cleft Lip/Palate	□ Physical Abnormalities	□ Ear Infections
□ Cross-eyed	□ Dental Problems	□ Diphtheria	□ Ear Tubes
□ Chronic Laryngitis	□ Measles	□ Pneumonia	□ Tonsillitis
□ Congenital Defects	□ Meningitis	□ Polio	□ Tuberculosis
□ Cataracts	□ Metal Implants	□ Reflux	□ Whooping Cough
□ Diabetes: Type I or II	□ Dizziness/Fainting	□ Rheumatoid Arthritis	□ Mumps
□ Vision Problems	□ Bowel/bladder issues	□ Asthma/Breathing Difficulties	□ RSV
□ Night Pain	□ Seizures/Epilepsy	□ Other: _____	

Previous Hospitalizations, Surgeries, and Procedures?

Date_____ Surgery/Reason_____

Date_____ Surgery/Reason_____

Does your child have any movement restrictions? □ Yes □ No

If Yes, please list: _____

Is there any other information regarding your child's medical history that we should know about? _____

_____

Are there any factors that may complicate your child's ability to participate in therapy? □ Yes □ No

If Yes, please explain: _____

_____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

□ Yes □ No Explain: _____

***THERAPIST USE ONLY*: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below**

Please List Previous Medical History or Co-Morbidities that May Impact Rate of Recovery: _____

_____

Patient Name: _____ Date of Birth: _____ Date of Eval: _____

FEEDING

Describe any feeding problems? _____
Food likes? _____Food dislikes? _____

***THERAPIST USE ONLY*: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below**

Other Related Information: _____

_____

_____

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (i.e.: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]: _____

_____

_____

COMMUNICATION HISTORY

Child's Primary Communication: □ Verbal □ Non-Verbal □ None
What language(s) is spoke in the home? _____

Methods of Communication Used:
□ Vocalizations □ Single Words □ Two word phrases □ Facial Expression □ Manual Sign Language
□ Body Language □ Pointing □ Gestures □ Eye Gaze
Please describe any communication difficulties: _____

Communication concerns? □ Yes □ No Comments_____

Are there hearing concerns? □ Yes □ No Comments_____

Are there vision concerns? □ Yes □ No Comments_____

***THERAPIST USE ONLY*: I have reviewed the information provided and: ☐ Information is complete ☐ Additional comments below**

Other Related Information: _____

_____

_____

SOCIAL HISTORY/INTERESTS/LIVING ENVIRONMENT

Father's Name: _____ Age: _____ Occupation: _____
Mother's Name: _____ Age: _____ Occupation: _____
Is he/she adopted? □ Yes □ No If Yes, at what age? _____
Parent's Marital Status □ Married □ Living Together □ Separated □ Divorced □ Remarried
Child lives with: □ Birth Parents □ Foster Parents □ One Parent □ Adoptive Parents □ Parent and Stepparent □Other
Sibling Name: _____ Age: ____ Speech, Motor, Hearing, Vision, or Medical Problems: _____
Sibling Name: _____ Age: ____ Speech, Motor, Hearing, Vision, or Medical Problems: _____
Sibling Name: _____ Age: ____ Speech, Motor, Hearing, Vision, or Medical Problems: _____

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

EDUCATIONAL HISTORY

Does your child attend school? □ Yes □ No **Has your child ever repeated a grade?** □ Yes □ No
If Yes, where?_____ **If Yes, what grade(s)?**_____
What grade is he/she in? _____
Setting: □ Home □ Home with Caregiver □ Daycare □ School
Name of Current School: _____

Does your child have?: □ IFSP □ IEP □ 504 Plan □ Other _____

Does your child have Special Education or Therapy services in school? □ Yes □ No
If Yes, what services? □ Physical Therapy □ Occupational Therapy □ Speech Therapy □ Adaptive PE
□ Reading Specialist □ Social Work □ Aide Psychologist □ LD Resource □ Other_____
How often? _____ **How long?** _____
Individual/group? _____
Additional Comments: _____

Has your child received Therapy anywhere else? □ Yes □ No
If Yes, what services? □ Physical Therapy □ Occupational Therapy □ Speech Therapy
Where? _____
By whom? _____
Additional Comments: _____

Are there any religious or cultural issues that we should be aware of regarding your child's evaluation? _____
_____

PATIENT GOALS FOR THERAPY

What goals are you hoping to have your child accomplish by participating in Therapy? _____
_____
_____

ADDITIONAL RELEVANT INFORMATION

***THERAPIST USE ONLY*:** _____
_____
_____
_____
_____
_____
_____
_____
_____

GUARDIAN SIGNATURE

To the best of my knowledge I have fully informed you of the history of my child's problem and current status.

Patient Guardian's Signature: _____ **Date:** _____

Relationship to Patient: _____

***THERAPIST USE ONLY*:**

Additional Evaluations Completed:

Discipline: _____ **Date:** _____ **Reviewed By:** _____

Discipline: _____ **Date:** _____ **Reviewed By:** _____

Discipline: _____ **Date:** _____ **Reviewed By:** _____