



Child Profile

*Please note: Not all information may be pertinent to your child

Date _____

Patient's Name: _____ Date of Birth: ___/___/___ Age: _____

Resides with Parents/Caregivers (names): _____

Pediatrician's name: _____ phone #: _____ fax: _____

Other Doctor's and specialists who is involved in your child's care:

Name	Specialty	Phone Number

Reason for referral: _____

Diagnosis/Concerns: _____

Names of siblings & age: _____

Medications: _____

Allergies – Food or Medicine? None specify _____

Diet restrictions? None GFCF no dairy other _____

Any medical concerns or restrictions? None specify _____

School attending: _____

School Therapist's Name(s) and Frequency: _____

Teacher Name: _____ phone: _____

Availability (check those that are appropriate):

attends school M T W Th F hours _____

other therapy appts? (indicate day/time for each)

PT _____ OT _____ SLP _____ ABA _____

naps? N/A typical times _____

daycare N/A typical times _____

parent's work schedule _____

best times for therapy AM _____ PM _____ mealtime _____ other _____

Developmental History

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Background Information

Patient's Name _____

full term pregnancy premature birth - # of weeks _____ Birth Weight _____ lbs _____ ozs

uncomplicated pregnancy vaginal delivery c-section APGAR scores ____/____

Complicated Pregnancy/Delivery: _____

Length of hospital stay following birth: _____ Difficulties breathing after birth? Yes No

Prior Surgeries/Hospitalizations/Illnesses & Dates: _____

Has your child ever had seizures? Yes No Type of Seizures _____

Motor Milestones – age achieved

Roll _____ Sit _____ Crawl _____ Pull to stand _____ Cruising _____ Stand alone _____ Walk _____

Dress self _____ Undress self _____ Fasteners _____ Toilet train _____

Covered cup _____ Finger feed _____ Spoon feed _____ Talk with simple words _____

Hearing Status: Date tested _____ WNL Not tested impaired screen full audio eval aids

Hx of recurrent ear infections? No Yes please detail _____

PE Tubes: _____

Vision Status: Date tested _____ WNL Not tested impaired vision tx full eval glasses

Feeding/Swallowing Status: nursing Using: bottle sippy cup open cup straw

Eating habits: _____

Difficulty breathing after eating? No Yes please describe _____

Reflux? No Yes Please Describe _____

Swallow Study? No Yes Date _____

Current communication: points/gestures signs verbal PECS aug com device _____

Description: _____

Concerns? _____

Past therapies/interventions: _____

Adaptive equipment used: _____

Favorite toys/games: _____

Play skills: plays alone along side of others interacts with others sharing

Additional Information _____