



General Information

Child's Name:	DOB:
Medications currently taking:	
Allergies:	
Current Physician(s) & Providers:	
Current Concerns:	
Current Diagnosis:	
Significant family medical history:	
Special diet restrictions:	
Family strengths:	
Names of siblings & age:	
School attending:	Phone number:
School therapist's names & frequency:	

Birth History

How many weeks gestation was your child at birth? _____ weeks
Weight: _____ Height _____
Child was born via:
<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> unknown
Were there any complications with pregnancy or birth? (explain)
Significant birth history information (pregnancy, labor, delivery, and post-delivery)



Medical History

Most recent vision exam: _____	Most recent hearing exam: _____
Results:	Results:
Current Diagnosis:	
Significant family medical history:	
Special diet restrictions:	
Serious Illnesses:	
Hospitalizations:	
Physical Problems:	
Other diagnoses	
Current medications:	
Frequent colds:	
Ear infections:	
Hearing problem:	
Allergies:	
PE tubes:	

Motor Milestones-age achieved

Rolled over: _____	Sat up: _____
Crawled: _____	Pull to stand: _____
Cruising (walking around furniture): _____	Standing alone: _____
Walking alone: _____	Toilet trained: _____
Self-care	
Dressed: _____ undressed _____	
Buttons/zippers/snaps (fastening/unfastening)	

Oral Motor and Speech Milestones-age achieved

Used a cover cup: _____	Self-fed finger foods: _____
Spoon-fed self: _____	Talked with simple words: _____



Speech/Oral Motor

Was your child: <input type="checkbox"/> bottle-fed <input type="checkbox"/> breast-fed <input type="checkbox"/> tube-fed
Describe your child's significant past and current eating habits:
Does your child have difficulty breathing after eating? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was your child ever diagnosed with reflux? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child ever had a swallow study? (if yes, when?) <input type="checkbox"/> Yes_____ <input type="checkbox"/> No
Describe how your child currently communicates:
What are your current communication/feeding concerns?

Past Therapies/Interventions

What therapies/interventions has the child received in the past? What was the frequency they were seen?	
	Frequency
<input type="checkbox"/> Birth to three	_____
<input type="checkbox"/> OT	_____
<input type="checkbox"/> PT	_____
<input type="checkbox"/> ST	_____



Concerns (check all that apply) & comment on each:

- ____ Coordination _____
- ____ Moving about _____
- ____ Strength _____
- ____ Balance _____
- ____ Sensory issues _____
- ____ Attention span _____
- ____ School problems _____
- ____ Handwriting _____
- ____ Dressing _____
- ____ Feeding _____
- ____ Playing with others _____

Socialization

Describe your child's temperament: _____ _____ _____ _____
What are your child's favorite toys and/or games?
What frustrates your child?
What calms your child?
What are your child's play skills?
<input type="checkbox"/> Alone <input type="checkbox"/> along side of others <input type="checkbox"/> interacts with others <input type="checkbox"/> Sharing



Parent/Caregiver Goals

What are your goals for therapy?