Medical History

Patient Name: _____

Pregnancy / Delivery

Pregnancy Proceeded ☐ Without Complications
☐ With Complications

- ☐ Eclampsia
- ☐ Gestational Diabetes
- ☐ Multiple Births
- ☐ Polyhydramnios
- ☐ Positive for Cytomegalovirus 'CMV'
- ☐ Positive for Herpes
- ☐ Positive for HIV
- ☐ Positive for Strep B
- ☐ Pre-eclampsia
- ☐ Premature Labor
- ☐ Substance Exposure
- ☐ Toxemia
- ☐ Other _____

Length of Pregnancy (in weeks) _____ Prenatal care was ☐ Received ☐ Not Received

Delivery Proceeded ☐ Without Complications
☐ With Complications

- ☐ Abruptio Placenta
- ☐ Breech Presentation
- ☐ Low Birth Weight
- ☐ Negative Vacuum
- ☐ Non-progressive/unproductive Labor
- ☐ Occiput Posterior Postion (Face up)
- ☐ Placenta Previa
- ☐ Premature Rupture of Membranes
- ☐ Transverse Presentation
- ☐ Prolapsed Cord
- ☐ Use of Forceps
- ☐ Uterine Rupture
- ☐ Umbilical Cord Wrapped Around Neck
- ☐ Other _____

Delivery was ☐ Vaginal ☐ C-section ☐ Emergency C-section Length of child's hospital stay: _____

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

Needed to be transferred to another hospital ☐ Yes ☐ No

Transfer Hospital _____

Birth Weight _____ Birth Height _____ Apgar 1 min _____ 5 min _____ 10 min _____

Additional Comments _____

_____

_____

Multiple child pregnancies: # of live births: _____ # of still births: _____

Additional details of birth _____

_____

_____

Complications Following Birth

- ☐ Anemia of Prematurity
- ☐ Bronchopulmonary Dysplasia 'BPD'
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Club Foot
- ☐ Cytomegalovirus
- ☐ ECMO
- ☐ Failure to Thrive
- ☐ Hyperbilirubinemia
- ☐ Intrauterine Growth Retardation 'IUGR'
- ☐ IVH Bleed Grade I
- ☐ IVH Bleed Grade II
- ☐ IVH Bleed Grade III
- ☐ IVH Bleed Grade IV
- ☐ Jaundice treated by light therapy &/or blanket
- ☐ Meconium Aspiration
- ☐ Necrotizing Enterocolitis 'NEC'
- ☐ Neonatal hypoxia
- ☐ Oxygen dependency
- ☐ PDA
- ☐ Positive dependency
- ☐ Respiratory Distress Syndrome
- ☐ Respiratory Stridor
- ☐ Respiratory Syncytial Virus 'RSV'
- ☐ Retinopathy of Prematurity 'ROP'
- ☐ Thrombocytopenia (Low Platelet count)
- ☐ Ventilator Dependency
- ☐ VP Shunt
- ☐ Other _____

Diagnosed or Suspected Syndromes

_____

_____

Current Medications

_____

_____

_____

_____

Allergies

_____

_____

_____

Current Vitamins, Herbs, Minerals, Homeopathics

_____

_____

Hearing Test

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Last Test Date _____

Results

_____

_____

_____

Concerns

_____

_____

_____

Vision Test

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Last Test Date _____

Results

_____

_____

_____

Concerns

_____

_____

_____

Current Physicians			
Name	**Specialty**	**Reason**	**Date of last visit**

Diagnostic Tests		
Test	**When**	**Details/Results**
Auditory Brainstem Response		
Biopsy		
Blood Work / Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-Ray		

Surgeries and Procedures		
Type	**Date**	**Results/Details**

Does the child have:

- ☐ Allergies
- ☐ Arteriovenous malformation (AVM)
- ☐ Anoxic brain injury
- ☐ Asthma/respiratory breathing problems
- ☐ Autism
- ☐ Baclofen Pump
- ☐ Cerebral Palsy (CP)
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Chronic Ear Infections
- ☐ Colic
- ☐ Constipation
- ☐ Diarrhea
- ☐ Down Syndrome
- ☐ Hip subluxation
- ☐ Hydrocele
- ☐ Laryngomalacia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Periventricular Leukomalacia
- ☐ Reflux
- ☐ Scoliosis Degrees? _____
- ☐ Seizure Condition
- ☐ Sleep disorder
- ☐ Sleep problems
- ☐ Shunts
- ☐ Torticollis
- ☐ Traumatic brain injury (TBI)
- ☐ Tube Feeding
- ☐ Tubes in ears
- ☐ Vagal Nerve Stimulator
- ☐ None

Other Medical Conditions

_____

_____

_____

Orthopedic Conditions

_____

_____

_____

Additional Comments

_____

_____

_____

Developmental History

Is the child able to:	Began at age (in months):
Bringing both hands to mouth	
Buttoning pants/shirt	
Come to sitting from a lying position	
Creeping or crawling alone	
Fully Toilet trained	
Grabbing a toy	
Holding head up alone	
Pulling self to standing position	
Rolling Over	
Self-bathing	
Self dressing	
Sitting alone without support	
Standing unsupported	
Tying shoes	
Walking with support	
Walking unaided	
Zipping/unzipping jacket	

Is your child ☐ Right Handed ☐ Left Handed ☐ Neither

Concerns about handwriting? ☐ Yes ☐ No Describe: _____

How does child get around the house? _____

Favorite Toys / Play Activities _____

Description of Child

☐ Active ☐ Affectionate ☐ Aggressive ☐ Calm
☐ Cautious ☐ Curious ☐ Demanding ☐ Difficult to Comfort
☐ Distractible ☐ Fearful ☐ Fearless ☐ Fussy
☐ Insecure ☐ Motivated ☐ Passive ☐ Persistent
☐ Playful ☐ Shy ☐ Stubborn ☐ Withdrawn
☐ Other: _____

Sensory processing & Regulation (please select all that apply)

☐ Avoids getting messy
☐ Seeks out (craves) touch or movement
☐ Stumbles or falls frequently
☐ Appears awkward or less coordinated
☐ Flaps hands
☐ Allows brushing of teeth
☐ Bangs on surface, bangs/hits head
☐ Fatigues quickly
☐ Has self-abusive behaviors
☐ Resists certain tasks or environment
☐ Spins things or self
☐ Is sensitive to lights,sounds or noise
☐ Sleeps a lot
☐ Resists touch
☐ Walks on toes
☐ Lines up toys or objects
☐ Seeks out (craves) visually stimulating objects
☐ Seeks out (craves) stimulating sounds
☐ Resists certain movements (e.g. bouncing, swinging, upside down)
☐ Has difficulty figuring out how to move body or takes more time with movements
☐ Does not tolerate certain textures (e.g. clothing,surfaces,foods)
☐ Uses lots of pressure when touching someone or holding object
☐ Has difficulty transitioning from one activity to another
☐ Has difficulty falling asleep
☐ Has difficulty remaining asleep through the night
☐ Appears Lethargic/sleepy all the time
☐ Has poor sense of body in space, runs into things
☐ Seeks support for posture (e.g. leans on furniture, walls or people, holds head)
☐ Demonstrates stiff or rigid movement patterns
☐ Hyperfocussed (on specific tasks, people, objects, etc.)

Other: please describe_____

Social/Emotional Skills

- ☐ Is easily distracted
- ☐ Calms self easily
- ☐ Gets angry/frustrated easily
- ☐ Is aggressive towards others
- ☐ Prone to emotional outbursts
- ☐ Doesn't allow others to join in play
- ☐ Has difficulty making friends
- ☐ Plays with peers
- ☐ Other: please describe_____
- ☐ Only plays with adults
- ☐ Prefers to play alone
- ☐ Has difficulty with separations
- ☐ Has poor eye contact

Feeding

Describe Any Feeding Problems

_____

Food Likes

_____

_____

Food Dislikes

_____

_____

Feeding Milestones			
When did the child begin?	**Age (in months)**	**Milestone**	**Age (in months)**
Using a Bottle		Using a Straw	
Using a Pacifier		Stop Using a Bottle	
Eating baby food		Stop Using a Pacifier	
Eating junior food		Using Utensils to Eat	
Eating table food		Holding own bottle/cup	
Drinking from a Cup		Self-feeding	
Drinking from a Sippy Cup			

Breast Feeding

- ☐ # times currently breast fed per day _____ ☐ Weaned from breast feeding at age: _____
- ☐ Was never breast fed

Current Feeding Adaptations

- ☐ Thickened Liquids: Consistency: _____
- ☐ Adapted Utensils Details: _____
- ☐ Adapted seating Details: _____
- ☐ Calorie supplements Details: _____
- ☐ Tube Feeding Amount: _____ Times per day: _____ ☐ Continuous ☐ Bolus

Areas of Difficulty

- ☐ Chewing ☐ Drooling ☐ Transitioning Between Foods ☐ Jaw shifts/slides/juts
- ☐ Communication Needs ☐ Swallowing ☐ Understanding Words

Speech Language

Communication Skills		
Does the child:	Yes	No
Have speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

Speech Milestones			
When did the child begin?	**Age (in months)**	**Milestone**	**Age (in months)**
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

First Words _____

Augmentative Communication Device _____

Primary Communication ☐ Verbal ☐ Non-Verbal ☐ None

Methods of communication used:

☐ Vocalizations ☐ 2 word Phrases ☐ Facial Expressions ☐ Manual Sign Language ☐ Pointing
☐ Single Words ☐ Complete Sentences ☐ Body Language ☐ Gestures ☐ Eye Gaze

Please describe current speech concerns: _____

_____

_____

_____

Home Environment

Child lives with: (Please select all that apply)

☐ Birth mother ☐ Step-mother ☐ Siblings
☐ Birth father ☐ Step-father Please list siblings ages: _____
☐ Adoptive mother ☐ Grandmother ☐ other relative
☐ Adoptive father ☐ Grandfather Please specify: _____
☐ Legal guardian
Please specify: _____

Additional Comments: _____

_____

_____

Adoption

Age at adoption: _____

Additional Details: _____

Type of Home

☐ Single Level ☐ Assisted Living Facility
☐ 2 Level ☐ Skilled Nursing Facility
☐ Ground Floor Apartment ☐ Group Home
☐ Upper Level Apartment ☐ Other _____

Accessibility

Stairs to get into home: _____ Handrail? ☐ Right ☐ Left ☐ None
Ramp to get into home? ☐ Yes ☐ No
Stairs in home: _____ Handrail? ☐ Right ☐ Left ☐ None

☐ Bathroom on Main Level ☐ Bedroom on Main Level
☐ Bathroom on Upper Level ☐ Bedroom on Upper Level

Additional Comments: _____

_____

_____

Equipment presently used (Please select all that apply)

Equipment	Approx. Age	Details	Uses at Home	Uses at School/Day Care
Braces				
Walker				
Stander				
Manual Wheelchair				
Power Wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splint(s)				
Track System				
Other:				

Describe any home program that is currently performed (e.g. stretching, strengthening, brushing, etc)

_____

_____

_____

Describe any community groups or sports activities the child is involved in

_____

_____

Grade in School _____ Name of School _____

Does your child have an IFSP? ☐ Yes ☐ No

Does your child have an IEP from school? ☐ Yes ☐ No

Has your child had a psychological or neuropsychological evaluation completed? ☐ Yes ☐ No

Therapy Services	Type	Status	How often?	Where?
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental History				
EI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Therapy				
Speech / Language Therapy				
Developmental Follow-up Clinic				
Other:				

Additional Comments: _____

_____

_____