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PEDIATRIC PATIENT HISTORY

Date:_____ Child's Name:_____ Date of Birth:_____
Age:_____ Does your child attend school? _____What grade? _____Where?_____

Primary language spoken in the home:_____Other languages Spoken?_____
Diagnosis: _____ Doctor:_____

Please list persons living in the home with the child: Parents: _____

Siblings (Name and Age):_____

Other:_____
Has your child ever had an evaluation or received Occupational, Physical, or Speech Therapy before? When, Where and by Whom?

Did your child receive any services from the Idaho Infant-Toddler Program?

Does your child receive SPEECH, PHYSICAL, or OCCUPATIONAL therapy at school? (Please Circle)

Please circle all areas of concern:

Speech Language Following Directions Attention Memory Reading

Writing Social Skills Throwing/Catching Eating Constipation Bladder Control

Balance Walking Falls Frequently Coordination Endurance

Please list your child's Strengths:

Please list your child's weaknesses:

What things would you like to see your child do, or do better? What are your goals for therapy? Reason for Referral?

Do you have any concerns about your child's performance in school?

DEVELOPMENTAL HISTORY:

Check which is applicable: This child is my _____biological, _____adopted, _____ foster child?

Please list any complications which occurred during pregnancy and which month they occurred.

Babies Birth Weight: _____ Birth Length:_____ Birth Place:_____

Was the child born after a full term pregnancy:_____ If no, how many weeks: _____

How long was labor:_____ Was labor induced:_____

Were instruments used:_____ Type of delivery: Vaginal Breech Cesarean

Was the baby transferred to the NICU or required extra time in the hospital? Yes or no ? If yes, how long did they stay?_____ What type of medical support did they need?_____

Please circle any conditions that existed for the baby at birth:

Paralysis	Birth defects	Feeding tube (Length of time)_____
Fractures	Multiple births	Needed Oxygen (Length of time)_____
Seizures	HIV Positive	Surgeries (Why?)_____
Bruised Head	Did not cry quickly	Blue Color for a long time
Cord around neck	Low Apgar scores	Other? _____

Please indicate the approximate age at which your child……?

Held their head up unsupported _____ Sat unsupported _____Crawled _____
Walked _____Rode a bicycle/tricycle _____ Walked up/down stairs _____
Eat finger foods _____Eat with a spoon _____Erupted first tooth _____
Potty Trained_____ Make babbling/cooing sounds_____ Say his/her first words_____

Has your child ever been in the hospital, had a serious accident, or had a serious illness? (If yes, please explain)

Has your child had frequent illnesses or infections, such as ear infections? (If yes, please explain how often and what kind of infection)

Does your child have seizures? How often? _____ Certain time of day?_____

How do you recognize a seizure and what do you do for your child when they are having a seizure?

Please list all medications your child is presently taking and their purpose?

Has your child seen a specialist for any medical condition?(Please list which doctors, type of problem, and approximate dates.)

VISION AND HEARING INFORMATION: **My child has…**

_____ had a hearing exam: Date:_____ Results: _____

_____ had a vision exam: Date: _____ Results: _____

Warning signs of vision problems…. Does your child exhibit any of the following: ***Please Circle***

Complaints of headache or eye pain	Excessive blinking or squinting	Gets close to near work
Eyes turn in or out, up or down	Rubs eyes frequently	Turning or tilting head
Closes or covers one eye	Chronic red eyes	

ADAPTIVE SKILL INFORMATION:

On a scale of 1 to 4, how well does the child function in the following areas? (circle one)
1=Completely dependent on others. Needs lots of help or cues. 4=Completely independent. No difficulties in this area.

Dressing Upper Body	1	2	3	4	Not Applicable
Dressing Lower Body	1	2	3	4	Not Applicable
Toileting	1	2	3	4	Not Applicable
Eating (breast or bottle)	1	2	3	4	Not Applicable
Eating (soft foods off spoon)	1	2	3	4	Not Applicable
Eating (with fingers)	1	2	3	4	Not Applicable
Eating (with utensils)	1	2	3	4	Not Applicable
Playing with familiar peers	1	2	3	4	Not Applicable
Playing with unfamiliar peers	1	2	3	4	Not Applicable
Handwriting	1	2	3	4	Not Applicable
Frustration tolerance	1	2	3	4	Not Applicable
Sleeping routine	1	2	3	4	Not Applicable
Grooming (hair)	1	2	3	4	Not Applicable
Grooming (bathing)	1	2	3	4	Not Applicable
Grooming (teeth)	1	2	3	4	Not Applicable
Maintaining attention to tasks	1	2	3	4	Not Applicable
Entertaining self	1	2	3	4	Not Applicable
Hand/Eye coordination	1	2	3	4	Not Applicable
Balance	1	2	3	4	Not Applicable

Following verbal directions	1	2	3	4	Not Applicable
Safety awareness	1	2	3	4	Not Applicable
Cutting with scissors	1	2	3	4	Not Applicable

Did your child have feeding problems? _____ Comments:_____

_____ Excessive length of time to drink a bottle **_____sucking or nursing**

_____Regurgitation of liquids/solids through nose **_____ Difficulty gaining weight**

_____ Difficulty chewing/swallowing meats **_____Choking and/or gagging**

_____Picky eater **_____ Excessive drool**

SOCIAL INFORMATION:

My …. (check all those that apply):

_____Gets along with other children

_____Prefers to play NEXT TO other children (minimal to not talking among children)

_____Prefers to play WITH other children (playing and talking jointly)

_____Prefers to play alone

Please describe your child's play. What does he/she like to play? What are his/her favorite games and toys?

Please list and describe any concerns you may have about your child's behavior:

SPEECH, LANGUAGE, AND HEARING INFORMATION:

Please check all areas below that are of concern to you with regard to your child:

_____Production of speech sounds **_____Hearing**

_____Understanding/following directions **_____Understanding/speaking English**

_____Understand what is said to him/her **_____Stuttering/fluency**

_____Voice **_____Expressing ideas, wants, needs (language)**

Describe/give examples of your concerns with the areas you checked above:

Are your concerns related to a specific incident/event? If yes, please describe:

Does your child seem to recognize his/her communication difficulty?_____If so, what does the child do?

If your child's communicatipn varies, under what conditions does it become……..

1. **Better:**_____
2. **Worse:**_____

Check the items that your child seems to do more than other children the same age:

_____Avoids speaking at school/preschool/daycare _____Avoids speaking to adults

_____Avoids speaking when playing with others _____Avoids saying certain words

_____Avoids speaking at home _____Cries when unable to communicate

_____Avoids speaking to children _____Becomes aggressive when unable to communicate

Please give examples of your child's first words_____

Does your child put words together (ex."more milk")?_____ How many words are in your child's longest utterances? Please give examples:

Does your child make sounds incorrectly?_____ If so, please give examples:

How well is your child understood by: (percentage of time)

Parents?_____ Family Friends? _____ Siblings?_____ Strangers? _____

My child can…(check those that apply)

_____Say a nursery rhyme ____ Tell about past events

_____Answer simple Questions ____Tell a simple story

_____Get a common object when asked to do so ____ Tell about immediate events

_____Follow one-step commands ("wash your hands") ____ Remember what is told to him/her

_____Follow more difficult directions ("get your book and give it to dad")

Does your child use the SAME, MORE, or LESS number of words as other children the same age? (circle one)

**Thank you for completing this lengthy form. It will be valuable in helping us meet your child's individual needs.