Up Pediatric Therapy Movin' PC

MEDICAL AND SENSORY HISTORY

Date: _____

Child's Name: _____ Child's DOB: _____

Please give a brief summary of your primary concerns for your child: _____

_____

_____

_____

_____

Primary language spoken in home: _____
Name of School child attends: _____ School District:_____
Special Services receiving currently: _____
Does your child receive services through CCS or Regional Center?: _____
What medical specialists has your child been seen by, and when? (neurologist, etc.): _____

_____

Please liste dates and sources of previous therapy your child has received: _____

_____

_____

BIRTH HISTORY

List any complications during pregnancy (illnesses, injuries, anemia surgeries, medical complications, Pre-eclampsia? etc.): _____

_____

_____

Were any drugs or medications taken during pregnancy? Please specify: _____

_____

Were there any complications during labor or delivery?: _____

_____

What type of delivery did you have? (vaginal, c-section, induction, etc.) _____
What was the child's gestational age (length of pregnancy): _____
Child's birth weight: _____ Birth length: _____ Child's APGAR scores: _____
Child's length of stay in hospital: _____

Did your child receive any special treatment/procedures during this hospitalization? (respirator, intubation, surgery): _____

_____

Did your child go home with any special monitors or equipment?: _____

_____

MEDICAL HISTORY

Check any of the following that your child has/had:

Serious illness: _____ **Serious accident: _____**
Repeated ear infections: _____ **PE tubes placed in ears: _____**
Allergies: _____ **Asthma: _____**

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MEDICAL HISTORY

Hepatitis: _____ **CMV:** _____
HIV: _____ **Recent significant weight loss or gain?:** _____

Heart conditions: _____ **If yes, are there any precautions?** _____
Heart surgery: _____ **If yes, what date(s)?** _____
Seizure disorder: _____ **If yes, when was last seizure?** _____
Is the seizure disorder controlled? _____

Hospitalizations: _____

_____

Surgeries: _____

_____

Does your child currently require any special equipment including orthotics (braces)?: _____

_____

Is your child currently on any medications?If yes, please list: _____

_____

What studies have been done (EEG, CAT Scan, MRI, X-Rays, Visions, Hearting, etc.)? List findings:

_____

_____

DEVELOPMENTAL HISTORY

Please indicate the approximate age when your child achieved the following milestones:

Rolling over: _____ **Sitting independently:** _____
Crawling on stomach: _____ **Crawling on all fours:** _____
Walking: _____ **Using first word:** _____
Using two words together: _____

What type of foods does your child eat?:_____

_____

SENSORY HISTORY:

Would you say that your child overreacts, under reacts, or has a normal reaction to the following?			
	Overreacts	**Under Reacts**	**Normal Reaction**
Touch	☐	☐	☐
Sound	☐	☐	☐
Smell	☐	☐	☐
Light	☐	☐	☐
Pain	☐	☐	☐
Messy play	☐	☐	☐
Getting dirty	☐	☐	☐
Having hair washed	☐	☐	☐

	Overreacts	Under Reacts	Normal Reaction
Having face washed	☐	☐	☐
Trying new foods	☐	☐	☐
Wearing new clothes	☐	☐	☐
Going barefoot	☐	☐	☐
Swinging	☐	☐	☐
Spinning	☐	☐	☐
Riding in the car	☐	☐	☐

DOES YOUR CHILD...	YES	NO	SOMETIMES
Pinch, bite, scratch or hit him/herself or others?	☐	☐	☐
Mouth toys or objects?	☐	☐	☐
Bang his/her head on purpose?	☐	☐	☐
Toe walk?	☐	☐	☐
Like to be in tight spaces?	☐	☐	☐
Avoid close contact with others?	☐	☐	☐
Swing?	☐	☐	☐
Spin?	☐	☐	☐
Climb?	☐	☐	☐
Slide?	☐	☐	☐
Enjoy playgrounds?	☐	☐	☐
Rock back and forth when sitting?	☐	☐	☐
Appear clumsy?	☐	☐	☐
Jump a lot?	☐	☐	☐
Crash into objects or fall on purpose?	☐	☐	☐
Identify body parts?	☐	☐	☐
Adjust to a threat to his/her balance?	☐	☐	☐
FINE MOTOR: DOES YOUR CHILD...	YES	NO	
Have poor coordination with small objects?	☐	☐	
Make reversals in writing when copying?	☐	☐	
Play with appropriate toys?	☐	☐	
Have a dominant hand?	☐	☐	
Indicate dominance (circle):	**Left**	**Right**	