Up Pediatric Therapy Movin' PC

SLP: MEDICAL HISTORY

Date: _____

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

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

_____

_____

_____

_____

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: _____

_____

Has your child attended any school/daycare/in home programs? ☐ YES ☐ NO

If yes, where?: _____

Does your child have any interest in storybooks? ☐ YES ☐ NO

If yes, how so? _____

Does your child point to any colors? ☐ YES ☐ NO If yes, which ones?

_____

Does your child count? ☐ YES ☐ NO If yes, how high?

_____

Has your child repeated a grade? ☐ YES ☐ NO If yes, which?

_____

What are your child's strengths and/orbest subjects? _____

Is your child having difficulty with any subjects? _____

_____

Is your child receiving any help in any subjects? _____

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: _____

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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: _____

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: _____

Has your child ever had any difficulty eating (chewing, swallowing, stuffing, pocketing, picky, food aversions, cup use)?: _____

_____

Does your child have an active or lingering thumb-sucking, finger sucking, or pacifier habit? _____

_____

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How would you describe your child as an infant (alert/active, difficult to calm, resistant or likes to be held, good or irregular sleep patterns, fussY or irritable, excessive crying, tense or floppy when held, responsive to surroundings)?_____

SPEECH AND LANGUAGE HISTORY

Did you child begin:

Cooing/babbling by 4 months? ☐ YES ☐ NO
Imitating sounds by 12 months? ☐ YES ☐ NO
Respond to name/peek-a-boo by 8 months? ☐ YES ☐ NO
Said first word by 15 months? ☐ YES ☐ NO
Using jargon* by 12 months? ☐ YES ☐ NO
Put 2 words together by 24 months? ☐ YES ☐ NO
Using short sentences by 36 months? ☐ YES ☐ NO
Did you child cry normally? ☐ YES ☐ NO

***(Jargon is defined as words that are not understandable, but are said in "sentences" where the child's inflection matches that of an adult, and sounds as if they are "saying" something.)**

Estimate how many words your child currently uses. _____
Has speech/language development ever been interrupted? _____Reversed?_____
If so, please explain: _____
Has there been a change in the child's speech/language development in the past 6 months? _____
If so, please explain: _____

Does your child…

☐ Choke on foods or liquids?
☐ Currently put toys/objects in his/her mouth?
☐ Brush his/her teeth and/or allow brushing?
☐Repeat sounds, words or phrases over and over?
☐ Understand what you are saying?
☐Respond correctly to yes/no questions?
☐ Retrieve/point to common objects upon request (ball, cup, shoe)
☐ Follow simple directions ("Shut the door", or "Get your shoes")?
☐ Respond correctly to: ☐Who ☐What ☐Where ☐When ☐Why questions?

Your child currently communicates using…

☐ Body language
☐ Sounds (vowels, grunting)
☐ Words (shoe, doggy, up)
☐ 2 to 4 word sentences
☐ Sentences longer than four words
☐ Other _____

Behavioral Characteristics (Check all that apply)

☐ Cooperative
☐ Restless
☐ Attentive
☐ Poor eye contact
☐ Willing to try new activities
☐ Easily distracted/short attention
☐ Destructive/Aggressive
☐ Separation difficulties
☐ Withdrawn
☐ Easily frustrated/ impulsive
☐ Inappropriate behavior
☐ Stubborn
☐ Self-abusive behavior
☐ Plays alone for reasonable length of time

LANGUAGE INFORMATION

Is there a language other than English spoken in the home? ☐ YES ☐ NO

If yes, which one? _____ Does the child speak the language? ☐ YES ☐ NO

Who speaks the language? _____ Does the child understand the language? ☐ YES ☐ NO

Which language does the child prefer to speak at home? _____

Are there any incidences of any of the following conditions among the child's family/close relatives?

	YES/NO?	EXPLAIN:
Speech Problems	☐ YES ☐ NO	
Hearing Problems	☐ YES ☐ NO	
Learning Disabilities	☐ YES ☐ NO	
Seizures/convulsions	☐ YES ☐ NO	
Mental Retardation	☐ YES ☐ NO	
Heart Disease	☐ YES ☐ NO	
Autism/Spectrum Disorder	☐ YES ☐ NO	

Do you feel your child has a speech problem? ☐ YES ☐ NO

If yes, please describe _____

_____

_____

Do you feel your child has a hearing problem? ☐ YES ☐ NO

If yes, please describe _____

_____

Has he/she ever had a speech evaluation/screening? ☐ YES ☐ NO If yes, when?

_____

What were you told? _____

_____

_____

Has he/she ever had a hearing evaluation/screening? ☐ YES ☐ NO If yes, when? _____

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What were you told? _____

_____

Has you child ever had speech therapy? ☐ **YES** ☐ **NO If yes, where and when?**

_____

What was he/she working on?_____

_____

_____

Is your child are of, or frustrated by, any speech/language difficulties? _____

What do you see as your child's most difficult problem in the home? _____

_____

_____

What do you see as your child's most difficult problem in school? _____

_____

_____