Up Pediatric Therapy Movin' PC

SLP:MEDICAL AND SENSORY HISTORY FORM

Child's Name _____ Date: _____
Child's DOB: _____ Medical Diagnosis: _____
Parent's Name: _____
Address: _____
Parent Cell Phone# _____
Parent Home Phone # _____
Parent Work Phone # _____
EMAIL: _____

Name of School Child Attends: _____
School District child lives in: _____
Present School Program: _____
Special Services receiving currently: _____
_____
Does your child have problems in school? _____
_____
Has your child attended any school/daycare/in home programs: ☐Yes ☐ No
If yes, where? _____

Does your child have any interest in story books? ☐Yes ☐ No
If yes, how so? _____

Does your child point to any colors? ☐Yes ☐ No
If yes, which ones? _____

Does your child name 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/or best subjects? _____
_____
_____

Is your child having difficulty with any subjects? _____

_____

Is your child receiving help in any subjects?_____

_____

Does your child receive services through CCS or Regional Center? _____

_____

What medical specialists has your child been seen by, and when? : (neurologist, etc)

_____

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

_____

_____

BIRTH HISTORY

List any complications during pregnancy (illnesses, injuries, anemia surgeries, medical complications etc.)

_____

_____

_____

Were any drugs or medications taken during pregnancy? Please specify

_____

Were there any complications during labor or delivery?_____

_____

Pre-eclampsia?_____

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 _____
Heart condition _____if yes, are there any precautions?_____
Heart surgery if yes, what date(s)?_____
Seizure disorder if yes, when was the last seizure?_____
Is the seizure disorder controlled?_____
Recent significant weight loss or gain
Hepatitis _____
CMV _____
HIV _____

RSV _____
Hospitalizations:_____
_____
_____
Surgeries:_____
_____
_____
Does your child currently require any special equipment including orthotics (braces)?_____
_____
Is your child currently on any medications?_____
_____
What studies have been done? List findings:
EEG_____
CAT SCAN_____
MRI_____
Hearing_____
X-rays_____
Vision_____

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? _____

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)?_____
_____
_____

V. Speech and Language History

Did your child cry normally? ☐Yes ☐ No
Did your child begin:
Cooing/babbling by 4 months? ☐Yes ☐ No
Respond to name/peek-a-boo by 8 months? ☐Yes ☐ No
Using jargon* by 12 months? ☐Yes ☐ No
Imitating sounds by 12 months? ☐Yes ☐ No
Said first word by 15 months? ☐Yes ☐ No
Put 2 words together by 24 months? ☐Yes ☐ No
Using short sentences by 36 months? ☐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 food or liquids?
☐ currently put toys/objects in his/her mouth?
☐ brush his/her teeth and/or allow brushing?

Does your child...
☐ repeat sounds, words or phrases over and over?
☐ understand what you are saying?
☐ retrieve/point to common objects upon request (ball, cup, shoe)?
☐ follow simple directions ("Shut the door" or "Get your shoes")?
☐ respond correctly to yes/no questions?
☐ 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
☐ plays alone for reasonable length of time	☐ destructive/aggressive
☐ separation difficulties	☐ withdrawn
☐ easily frustrated/impulsive	☐ inappropriate behavior
☐ stubborn	☐ self-abusive behavior

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
Does the child understand the language? ☐ Yes ☐ No
Who speaks the language? _____
Which language does the child prefer to speak at home? _____

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

	Y	N	Explain
1. Speech Problems	_____	_____	_____
2. Hearing Problems	_____	_____	_____
3. Learning Disabilities	_____	_____	_____
4. Seizures/convulsions	_____	_____	_____
5. Mental Retardation	_____	_____	_____
6. Heart Disease	_____	_____	_____
7. Autism/Spectrum Disorder	_____	_____	_____

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, where and when? _____
What were you told? _____

Has he/she ever had a hearing evaluation/screening? ☐Yes ☐ No
If yes, where and when? _____
What were you told? _____

Has your child ever had speech therapy? ☐Yes ☐ No
If yes, where and when? _____
What was he/she working on? _____

Is your child aware 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? _____

SENSORY HISTORY:

Would you say that your child over reacts or under reacts to the following?

	Overreacts	**Under Reacts**	**Normal Reaction**
Touch			
Sound			
Smell			
Light			
Pain			
Messyplay			
Getting dirty			
Having hair washed			
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?			

	Yes	*No*	*Sometimes*
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?		
Have a dominant hand?		
Indicate dominance	*Left*	*Right*
Play with age appropriate toys?		

Activities of Daily Living:

DOES YOUR CHILD...	*Yes*	*No*
Put shoes and socks on?		
Feed self?		
Button?		
Snap?		
Zip?		
Tie?		
Brush own teeth?		
Use the toilet?		
Dress self?		
Use sippy cup?		

(how often?)_____

Use bottle?_____

(how often?)_____

What types of foods does your child eat?_____

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

_____

Parent Signature:_____