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 #_____

Language Spoken in Home:_____

Name of School Child Attends:_____
School District child lives in:_____
Present School Program:_____
Special Services receiving currently:_____
_____
Does your child have problems in school?_____
_____
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:_____

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:_____