CLIENT INFORMATION

1. Child's Name: _____ Date of Birth: _____ Sex: _____

Home Address: _____

Mailing Address (if different than above): _____

Home Phone: _____ E-Mail: _____

2. Parent/Guardian/Spouse/Relative (Check box of financially responsible person(s)):

( ) Mother's Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____

( ) Father's Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____

( ) Spouse/Relative's Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____

Who has legal guardianship of the child? _____ Driver's License #: _____

Daycare Provider: _____

Address: _____ Contact #: _____

Emergency Contact Name: _____

Relationship to Child: _____ Contact #(s): _____

3. Medical Resources: (check box of prescribing physician)

( ) Child's Primary Physician: _____

Address: _____ City: _____ Zip: _____

Phone #: _____ Fax #: _____

Consultants (Neurologist/Orthopedist/Physical Medicine/etc.):

( ) Name: _____ Specialty: _____

Address: _____ City: _____ Zip: _____

Phone #: _____ Fax #: _____

( ) Name: _____ Specialty: _____

Address: _____ City: _____ Zip: _____

Phone #: _____ Fax #: _____

Has a diagnosis been given? If yes, please list: _____

_____

_____

Please list all other professionals involved in the care of your child (i.e. speech therapist, physical therapist, etc). Please document when services were initiated and length of services: _____

_____

_____

Have other medical professionals (i.e. psychologists, developmental pediatricians, optometrists, etc.) evaluated your child? If yes, please list who and when: _____

_____

_____

4. Family History:

Are both parents involved in child's care? Yes / No

Is your child adopted? Yes / No

Does your child have siblings? Yes / No
If yes, please list:

Names of siblings	Age	Sex	Attend School

Are any siblings adopted? Yes / No
Do all siblings live with your child? Yes / No Please indicate whom: _____

Do others live in the home besides immediate family? Yes / No
If yes, please list:

Name(s)	Relationship to Child	Age

With whom does the child spend most of his/her day? _____

Name others closely involved with child: _____

Are there any speech, physical, learning, or developmental problems among family members? Yes / No
If yes, please list:

Name(s)	Relationship to Child	Describe Problems

Additional Pertinent Family History or Home Situation: _____
_____
_____
_____

5. Social Information:

Is your child attending school? Yes / No
If yes, please list Name of School, Grade, and Teacher: _____
_____

Has your child ever been asked to leave a school? Yes / No
If yes, for what reason(s)? _____
_____

What are your primary concerns about this child? _____
_____
_____
_____

What are your goals for your child? What are your child's goals? _____
_____
_____
_____

How does your child use his/her free time? _____
_____
_____

Please list any community activities in which your child is involved (i.e., sports, clubs, scouts, etc.):
_____
_____
_____

Does your child play appropriately with toys? Yes / No
If no, please explain: _____
_____

Does your child play appropriately with others? Yes / No
If no, please explain: _____
_____

6. Medical History:

Pregnancy: Full Term / Premature If premature, how early? _____

Where was child born (city, state, and hospital)? _____

Mother's general health during pregnancy: Good Fair Poor
Were there any problems during the pregnancy? (i.e. illnesses, injuries, stress, bleeding, hypertension, etc.): Yes / No
If yes, please explain: _____
_____
Were there any problems during labor and/or delivery? Yes / No
If yes, please explain: _____
_____

Birth: Child's Birth Weight: _____ lbs. _____ oz.
Was delivery C-section or vaginal? _____
Complications: Jaundice _____ Cyanosis _____ Congenital defects _____
Limpness _____ Stiffness _____ Other _____

Please elaborate on above complications at birth and note any others not included:

_____

_____

Was there any need for: Oxygen _____ Transfusions _____ Tube Feeding _____
If yes, please explain: _____

_____

Childhood: Is your child immunized? Yes / No Are immunizations up to date? Yes / No

Did your child or does he/she currently suffer from reflux? Yes / No
If yes, please describe symptoms and medications: _____

_____

Has your child had any serious illnesses or diseases besides those typical in childhood? Yes / No
If yes, please list name of illness/disease and age: _____

_____

_____

Has your child ever had x-rays, CT scans, MRI, or EEG? Yes / No
If yes, please list what the test was for, at what age the test was done, and what were the results:

_____

_____

_____

_____

Has your child had any injuries or surgeries? Yes / No
If yes, please describe the injury/surgery and the age it took place: _____

_____

_____

Does your child have allergies? Yes / No
If yes, please list items the child is allergic to and medications, if any: _____

_____

_____

Please list any medications currently taken on a regular basis:

Medication	Use	Dosage

Child's general health at present is: Good Fair Poor

7. Developmental History

Check which of the following describes your child as an infant:

_____Fussy, irritable	_____Good, non-demanding	_____Quiet
_____Passive	_____Active	_____Liked being held
_____Resisted being held	_____Floppy when held	_____Tense when held
_____Good sleep patterns	_____Irregular sleep patterns	_____Overactive, never still unless sleeping

Check which describes your child at present:

_____Mostly quiet	_____Overly active	_____Tires easily
_____Talks constantly	_____Too impulsive	_____Restless
_____Stubborn	_____Resistant to changes	_____Over reacts
_____Fights frequently	_____Usually happy	_____Temper tantrums
_____Clumsy	_____Nervous habits/tics	_____Falls often
_____Wets bed	_____Poor attention span	_____Easily frustrated
_____Cries often	_____Cries infrequently	_____Rocks self
_____Difficulty learning new tasks	_____Difficulty separating from primary caretakers	

Give approximate ages at which child did the following routinely:

_____ Held head up	_____ Belly crawled (on stomach)
_____ Crawled on hands & knees	_____ Sat alone
_____ Pulled to standing	_____ Stood alone
_____ Walked	

General impression of child's motor development:

Gross Motor:	Slow	Normal	Advanced
Fine Motor:	Slow	Normal	Advanced
Handwriting:	Poor	Normal	

Any discrepancies between your impressions and the school/daycare? Yes / No
If yes, please explain: _____

Self-Care:

For children under 4 years of age, was your child bottle fed, nursed, or both? _____
Were there any problems with either? Yes / No
If yes, please explain: _____
_____

Child currently eats:

_____Breast milk	_____Formula
_____Baby food	_____Junior foods
_____Mashed table foods	_____Table foods

Does your child object to certain foods (texture, taste, etc.)? Yes / No
If yes, please list and describe reaction (i.e. gagging, refusal, etc.): _____
_____

Describe the degree to which your child routinely performs the following:

Feeds self: All Most Some Rare None
If feeds self, which does your child usually use:
Bottle Fingers Spoon Fork

Bathes self: All Most Some None

Dresses self: All Most Some Rare None

Undresses self: All Most Some Rare None

Is child toilet trained? Yes / No
If yes, at what age? Bladder (daytime) _____ Bladder (day & night) _____ Bowel _____

Please list any daily living skills that your child is having difficulty with (i.e. fasteners, shoe tying, etc.):
_____
_____

8. Understanding Language and Communicating:

When you talk to your child, how much does he or she understand? (Check one):
_____A few words _____Many words and phrases
_____Simple directions _____Almost anything I say

Additional comments/examples: _____
_____

How does your child usually let you know what he or she wants? (Check all that apply)
_____Cries
_____Points
_____Points to what he/she wants
_____Uses gestures
_____Makes a few sounds
_____Uses a few words
_____Says many words, but only says one word at a time
_____Says two or three word sentences
_____Uses long sentences

Additional comments/examples: _____
_____

Has your child achieved skills and then lost them? Yes / No
If yes, please explain: _____
_____