BACKGROUND INFORMATION

Please fill out to the best of your ability and try not to skip any questions that pertain to your child.

Child's Name: _____

Birthdate: _____ Age: _____

Parents/Guardians: _____

Siblings: _____

Referred By: _____

Reason for Referral: _____

_____

_____

Birth/Health History:

1. Child's Birth weight: _____ Length: _____
2. Was your child full-term? _____ Premature? _____ How many weeks? _____
   Overdue? _____ How many weeks? _____
3. Describe any hospitalization including days in ICU, days on ventilation, surgeries, medical interventions, etc.: _____
   _____
   _____
   _____
4. List any pertinent illnesses or injuries (ie. seizures, ear infections, asthma, etc.):
   _____
   _____
   _____
5. Has your child had tubes in ears? _____ When? _____
6. Is there a family history of any diseases or disabilities: _____
   _____
7. Please name the professionals your child has seen:
   Pediatrician _____ ENT _____
   Neurologist _____ Psychologist _____
   Orthopedist _____ Physical Therapist _____
   Ophthalmologist _____ Occupational Therapist _____
   Geneticist _____ Speech Therapist _____
   Other _____
8. List past medical tests, dates performed and results:
   _____
   _____
   _____
9. Has your child's Vision been tested? _____
   Hearing? _____
10. List medications and vitamins/supplements your child is taking: _____
    _____

Name:_____ Date: _____

Developmental History:

1. At what age or approximate age did your child....
   Roll over_____ Pull to stand_____ Babble _____
   Sit alone _____ Walk _____ Say 1st word _____
   Crawl_____ Use Phrases _____
2. Does our child have a history of sucking or feeding problems (ie, choking, gagging, reflux, etc.)? ___
   _____
3. Does your child have any food allergies? _____
   _____
4. Does your child have a preferred hand? Right?_____ Left?_____ Both?_____
5. When did you first become concerned about your child's motor or speech development?
   _____
6. Describe concerns in the area of gross motor function (ie. sitting, walking, jumping. etc.):

7. Describe concerns in the area of fine motor functions (ie. manipulation toys, coloring, cutting dressing, feeding, etc.):

8. Describe concerns in the area of communication (ie. speech sounds, following directions, gestures, etc.):

Behavior:

1. Describe your child's likes and dislikes: _____
   _____
   _____
2. What words best describe your child's behavior: _____
   _____
3. How does your child interact with peers? _____
   _____
4. How does your child interact with adults?_____
   _____
5. Does your child easily go to bed at night? _____
   _____
6. Does your child sleep well at naptime and at night:_____
   _____
7. Please feel free to share any other behavioral concerns:

Name:_____ Date: _____

DAYCARE/PRESCHOOL OR SCHOOL INFORMATION

1. Present Daycare/Preschool/School: _____
2. Address/Parish: _____
   Telephone number(s)_____
3. Teacher(s)_____
4. Grade:_____
5. Has your child received a multidisciplinary evaluation (MDE) or Pupil Appraisal evaluation?
   Describe results: _____
   _____
   _____
6. Is your child in a special class situation or receiving any special services? Please list.
   _____
   _____
   _____
7. List subjects or activities your child finds easy and enjoys. _____
   _____
   _____
   _____
8. List subjects or activities your child finds most difficult. _____
   _____
   _____
9. Has your child repeated a grade? _____ Please describe. _____
   _____
   _____
10. When did you become aware of school-related problems?: _____
    _____
    _____
11. List prior schools attended._____
    _____
    _____
12. Plans for next school year._____
    _____
    _____