



General Information:

Date form completed: _____

Child's Name: _____ Date of Birth: _____

Most Convenient Place and Number for you to be reached: _____

Caregiver's Name: _____ Occupation: _____

Caregiver's Name: _____ Occupation: _____

Caregiver's Name: _____ Occupation: _____

Name and ages of brothers and sisters: _____

Person to contact in case of emergency: _____

Does your child attend daycare or preschool? _____ If so, where? _____

Teacher's Name: _____ School: _____

Grade in School: _____ Teacher's Phone: _____

Referred by: _____

Does your child have interest in or participate in extracurricular or community-based activities? If so, what? _____

Medical Diagnosis (if any): _____

Has child had allergy testing? _____ Known/Suspected Allergies: _____

Medical History: If child has had any of the following, please describe and give approximate dates:

Major Illnesses: _____

Congenital Anomalies: _____

Serious Injury: _____



Medical History Continued:

Ear Infections: _____

Tubes in Ears: _____

Seizures: _____

Stomach or Bowel Problems (such as frequent diarrhea, soft stools or stomach aches):

Small uncontrolled movements in face or body (Tics): _____

History of Strep Infections: _____

Exposure to lead (live in old home or eat strange items): _____

Other: _____

List any medications your child is currently receiving, along with frequency and dosage:

Purpose and effect of medication:

Are there any medical precautions I should be aware of when working with your child?



Medical History Continued:

Previous Evaluations	Date	Name of Evaluator	Location of Evaluation	Date/ Frequency of Past or Current Services
Physical Therapy				
Occupational Therapy				
Speech/Language Pathology				
Behavioral Specialist				
Psychiatry				
Psychology				
Special Education/Cognitive				
Neurology				
Hearing				
Vision				
Other				

**** Please enclose a copy of evaluation(s)**

What do you hope to gain from this evaluation and/or treatment?

Child's Prenatal Period and Birth:

Were there any difficulties with conception or during pregnancy? _____

Were there any medications used during pregnancy? _____

Were there any medical problems during pregnancy (such as bleeding, infections, high blood pressure, diabetes, injuries or convulsions)? _____

Were there any complications during delivery and/or labor? If so, please explain:

Was child full term? _____ If premature, how many weeks? _____



Child's Prenatal Period and Birth continued:

Weight at birth: _____

Did child require intensive care hospitalization? If yes, for how long? _____

Infancy and Early Childhood:

Did your child.....

Have feeding problems or have difficulty transitioning to a variety of solid foods? If so, describe:

Have difficulty sleeping? _____

Prefer to be left alone to fall asleep? _____

Use a pacifier/fingers to self soothe? _____

Enjoy being swaddled? Need excessive swaddling to be soothed? _____

Have colic? If yes, for how long? _____

Need to stick to a strict routine in order to stay content? _____

Prefer certain positions as an infant? If yes, describe:

Dislike lying on stomach? _____ Dislike lying on back? _____

Arch back and pull away when held? _____

Enjoy bouncing? _____

Become calmed by car rides or infant swings? _____

Dislike or become nauseated by car rides or infant swings? _____

Tend to be generally compliant? _____



Infancy and Early Childhood continued:

Have difficulty calming once upset or become upset easily? _____

Did child have skills that were later lost (such as speech or physical development)? If yes, describe: _____

Visually engage with people? _____

Engage in vocal play (in back and forth manner) with familiar people? _____

Initiate interactions with familiar people? _____

Demonstrate curiosity about their environment? _____

Tolerate being dressed in a variety of textured clothing? (ie. Jeans, button shirts) _____

Have preferred toys and activities as a 12 month old? _____ Describe:

Developmental Milestones: Please give approximate ages if remembered and comment on anything unusual, such as a different method for “crawling”

Rolling over: from stomach _____ from back: _____ Sitting alone: _____

Crawling: _____ Was crawling phase brief, absent or unusual? _____

Walk as a primary form of getting around: _____ Babble: _____ Say words: _____

Say sentences: _____

Did child experience any hesitancy or delays in learning to go down stairs? _____

Please describe how your child communicates:



Bowel and Bladder:

Does or did your child:

Have trouble learning urinary control? _____ Continued to have accidents until age: _____

Have trouble learning bowel control? _____ Continued to have accidents until age: _____

Seem to have difficulty registering the need to eliminate? _____

Sleep Patterns:

Does your child:

Have regular sleep patterns? _____ If yes, describe: _____

Wake frequently during the night? _____

Tend to need very little sleep? _____

Tend to need more sleep than other children? _____

Tend to need extensive adult intervention to fall/stay asleep? _____

Tend to have a difficult time falling asleep? _____

School Skills:

If enrolled in school, is your child considered to have difficulty in any of the following? Check those that apply:

___Reading ___Math ___Spelling ___Handwriting ___Following Directions ___Finishing
Tasks ___Paying Attention ___Organizing Work ___Behavior ___Other: _____

Does your child receive special help? _____

Name of Special Educator: _____

Additional Comments regarding special services or educational plan:



Developmental Skills:

Can your child:	Yes	No
Turn pages of a book		
Play with puzzles with single pieces		
Play with puzzles that have interlocking pieces		
Hold arms and legs up for dressing		
Undress self independently		
Climb on and over objects		
Jump with both feet together		
Ride a tricycle while pedaling with feet		
Build with blocks, LEGO, or other materials		
Blow bubbles		
Blow whistles		
Engage and zip a jacket without help		
Tie shoes		
Suck through a straw		
Turn door handles independently		
Spit out toothpaste after brushing		
Kick a ball		
Button a shirt		
Dress independently		
Insist on dressing self		
Ride a bicycle with training wheels		
Ride a bicycle without training wheels		
Complete snaps and buckles independently		
Float on stomach and back in water		
Open car doors by self		
Jump rope		
Roller or ice skate		
Blow bubbles with gum		



Developmental Skills continued:	Yes	No
Swim using crawl or other strokes		
Use a fork and spoon to eat		
Feed self using hands		
Wash hands independently		

Family History:

Is there a family history of any of the following? If so, please state relationship (parent, grandparent, siblings, or others)?

	Yes	No	Relationship to Child	Description
Left hand preference or ambidexterity				
Learning difficulties				
Behavior challenges				
Neurological concerns (seizures, tics, muscle weakness)				
Mental health concerns (schizophrenia, bipolar disorder, depression, anxiety, etc.)				
Drug or alcohol abuse				
Other:				

Additional Comments:

Please feel free to include any information that you feel would assist me in getting to know and understand your child, especially your child's strength and methods for coping.

Thank you again for taking the time to complete this form.

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