Medical History

Please fill out this form to the best of your ability.
If a section does not apply to your child, you may write in "N/A".

Patient Name: ____ DOB: _______ / _______ / _______

Pregnancy/Delivery

Pregnancy Proceeded
- ☐ With Complications
  - ☐ Eclampsia
  - ☐ Gestational Diabetes
  - ☐ Multiple Births
  - ☐ Positive for Cytomegalovirus "CMV"
  - ☐ Positive for Herpes
  - ☐ Positive for HIV
  - ☐ Positive for Strep B
  - ☐ Pre-eclampsia
  - ☐ Premature Labor
  - ☐ Substance Exposure
  - ☐ Toxemia
  - ☐ Other: ______________________
- ☐ Without Complications

Prenatal care was ☐ received ☐ not received

Delivery Proceeded
- ☐ With Complications
  - ☐ Abruptio Placentae
  - ☐ Breech Presentation
  - ☐ Negative Vacuum
  - ☐ Placenta Previa
  - ☐ Premature Rupture of Membranes
  - ☐ Umbilical Cord Wrapped Around Neck
  - ☐ Prolapsed Cord
  - ☐ Transverse Presentation
  - ☐ Use of Forceps
  - ☐ Uterine Rupture
  - ☐ Other: ______________________
- ☐ Without Complications

Delivery was ☐ Vaginal ☐ C-section ☐ Emergency C-section

Length of Pregnancy (in weeks) __________ Days in Hospital: ________________

Mothers age at time of birth ____________ Birth Hospital ____________________________________

Needed to be transferred to another hospital ☐ Yes ☐ No Transfer Hospital ____________________________

Birth Weight ______________ Birth Height ________ Apgar 1 min _______ 5 min _______ 10 min _______

Following Birth

Complications Following Birth
- ☐ Anemia of Prematurity
- ☐ Bronchopulmonary Dysplasia 'BPD'
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Club Foot
- ☐ Cytomegalovirus 'CMV'
- ☐ ECMO
- ☐ Failure to Thrive
- ☐ Hyperbilirubinemia
- ☐ IVH Bleed Grade I
- ☐ IVH Bleed Grade II
- ☐ IVH Bleed Grade III
- ☐ IVH Bleed Grade IV
- ☐ Intrauterine Growth Restriction 'IUGR'
- ☐ Jaundice
- ☐ Meconium aspiration
- ☐ Necrotizing Enterocolitis 'NEC'
- ☐ Neonatal Hypoxia
- ☐ Oxygen Dependency
- ☐ PDA
- ☐ Positive Dependency
- ☐ Respiratory Distress Syndrome
- ☐ Respiratory Stridor
- ☐ Respiratory Syncytial Virus 'RSV'
- ☐ Retinopathy of Prematurity 'ROP'
- ☐ Thrombocytopenia
- ☐ Ventilator Dependency
- ☐ VP Shunt

Diagnosed or Suspected Syndromes:

Current Medications:

Allergies:

Current Vitamins, Herbs, Minerals, Homeopathic:

Hearing Test

☐ Never tested, no concerns
☐ Never tested, have concerns
☐ Normal test results
☐ Abnormal test results
Last Test Date: ___________________________
Results: ____
Concerns:

Vision Test

☐ Never tested, no concerns
☐ Never tested, have concerns
☐ Normal test results
☐ Abnormal test results
Last Test Date: ____________________________
Results: ____
Concerns:

Specialists Seen			
Specialist	**Name**	**Reason**	**Date of last visit**
Allergist			
Audiologist			
Cardiologist			
Cardiac Surgeon			
Chiropractor			
Developmental Medicine			
Endocrinologist			
ENT			
Family Medicine			
Gastroenterologist			
General Surgeon			
Geneticist			
Hand Surgeon			
Internal Medicine			
Nephrologist			
Neurosurgeon			
OBGYN			
Oncologist			
Ophthalmologist			
Orthopedic Surgeon			
Otolaryngologist			
Pediatrician			
Physiatrist			
Podiatrist			
Psychiatrist			
Rheumatologist			
Thoracic Surgeon			
Urologist			
Other:			

Surgeries and Procedures		
Type of Surgery	**Date**	**Details / Results**

Diagnostic Tests		
Test	**Date**	**Details / Results**
ABR / BAER		
Biopsy		
Blood Work		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI Endoscopy		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-Ray		

Health Issues

- ☐ Allergies
- ☐ Arteriovenous Malformation ‘AVM’
- ☐ Anoxic Brain Injury
- ☐ Asthma/respiratory breathing problems
- ☐ Autism
- ☐ Baclofen Pump
- ☐ Cerebral Palsy ‘CP’
- ☐ Cerebral Vascular Accident ‘CVA’
- ☐ Chronic Ear Infections
- ☐ Colic
- ☐ Constipation
- ☐ Diarrhea
- ☐ Down Syndrome
- ☐ Hip Subluxation
- ☐ Hydrocele
- ☐ Laryngomalacia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Periventricular Leukomalacia
- ☐ Reflux
- ☐ Seizure Condition
- ☐ Scoliosis Degrees: ______
- ☐ Sleep disorder
- ☐ Sleep problems
- ☐ Shunts
- ☐ Torticollis
- ☐ Traumatic Brain Injury ‘TBI’
- ☐ Tube Feeding
- ☐ Tubes In Ears
- ☐ Vagal Nerve Stimulator

Medical Condition(s):

Orthopedic Condition(s):

Comments:

Developmental History			
Milestone	**When (in months)**	**Milestone**	**When (in months)**
Bringing both hands to mouth		Self-bathing	
Buttoning pants/shirt		Self-dressing	
Come to sitting from lying without assistance		Sitting alone, no support	
Creeping or crawling alone		Standing unsupported	
Fully toilet trained		Tying shoes	
Grabbing a toy		Walking with support	
Holding head up alone		Walking unaided	
Pulling self to standing		Zipping/unzipping jacket	
Rolling over			

Is your child ☐ Right-handed ☐ Left-handed ☐ No hand preference

Are there concerns about handwriting? ☐ Yes ☐ No Please describe:

How does the child get around the house?

Favorite toys and play activities:

Description of child (select all that apply)

- ☐ Active
- ☐ Affectionate
- ☐ Aggressive
- ☐ Calm
- ☐ Cautious
- ☐ Curious
- ☐ Demanding
- ☐ Difficult to Comfort
- ☐ Distractible
- ☐ Fearful
- ☐ Fearless
- ☐ Fussy
- ☐ Insecure
- ☐ Motivated
- ☐ Passive
- ☐ Persistent
- ☐ Playful
- ☐ Shy
- ☐ Stubborn
- ☐ Withdrawn

Sensory Processing/Regulation (select all that apply)

- ☐ Avoids getting messy
- ☐ Seeks out (craves) touch or movement
- ☐ Stumbles or falls frequently
- ☐ Appears awkward or less coordinated
- ☐ Flaps hands
- ☐ Allows brushing of teeth
- ☐ Bangs on surface, bangs/hits head
- ☐ Fatigues quickly
- ☐ Has self-abusive behaviors
- ☐ Resists certain tasks or environments
- ☐ Spins things or self
- ☐ Is sensitive to lights, sounds, or noise
- ☐ Sleeps a lot
- ☐ Resists touch
- ☐ Walks on toes
- ☐ Lines up toys or objects
- ☐ Seeks out (craves) visually stimulating objects
- ☐ Seeks out (craves) stimulating sounds
- ☐ Resists certain movements (bouncing, swinging, etc)
- ☐ Has difficulty figuring out how to move body or takes more time with movements
- ☐ Does not tolerate certain textures (clothing, surfaces, foods)
- ☐ Uses a lot of pressure when touching someone or holding object
- ☐ Has difficulty transitioning from one activity to another
- ☐ Has difficulty falling asleep
- ☐ Has difficulty remaining asleep through the night
- ☐ Appears lethargic/sleepy all the time
- ☐ Has poor sense of body in space, runs into things
- ☐ Seeks support for posture (leans on furniture, holds head)
- ☐ Demonstrates stiff or rigid movement patterns
- ☐ Hyperfocused (on specific tasks, people, objects, etc)

Social/Emotional Skills (select all that apply)

- ☐ Is easily distracted
- ☐ Calms self easily
- ☐ Gets angry/frustrated easily
- ☐ Is aggressive towards others
- ☐ Prone to emotional outbursts
- ☐ Doesn't allow others to join in play
- ☐ Has difficulty making friends
- ☐ Plays with peers
- ☐ Only plays with adults
- ☐ Prefers to play alone
- ☐ Has difficulty with separations
- ☐ Has poor eye contact

Feeding

Describe any Feeding Problems:

Food Likes:

Food dislikes:

Feeding / Speech / Language History			
Milestone	**When (in months)**	**Milestone**	**When (in months)**
Using a bottle		Stop using a pacifier	
Using a pacifier		Using utensils to eat	
Eating baby food		Holding own bottle/cup	
Eating junior food		Self-feeding	
Eating table food		Babbling	
Drinking from a cup		Saying first words	
Drinking from a sip cup		Naming familiar objects	
Using a straw		Putting two words together	
Stop using a bottle		Using short sentences	

First words:

Breast Feeding?
☐ Currently; Times per day: _____
☐ Weaned; At age: _____
☐ Never

Current Feeding Adaptations
☐ Thickened Liquids Please specify:____
☐ Adapted Utensils Details: ____
☐ Adapted Seating Details: ____
☐ Calorie Supplements Details: ____
☐ Tube Feeding Amount: ___________________ Times per day: __________ ☐ Bolus ☐ Continuous

Areas of Difficulty
☐ Chewing ☐ Transitioning Between Foods ☐ Drooling ☐ Understanding Words
☐ Communication Needs ☐ Jaw Shifts / Slides / Juts ☐ Swallowing

Does the child:
Have speech that is understood by most people? ☐ Yes ☐ No
Respond correctly to yes/no questions? ☐ Yes ☐ No
Follow simple instructions? ☐ Yes ☐ No
Respond when name is called? ☐ Yes ☐ No
Stutter? ☐ Yes ☐ No
Recognize objects, people, and places? ☐ Yes ☐ No

The child's primary method of communication is: ☐ Verbal ☐ Non-verbal

Is an augmentative communication device used? ☐ Yes ☐ No
Details:

Select the primary methods of verbal communication used:
☐ None ☐ Vocalizations ☐ Single word phrases ☐ 2 word phrases ☐ Complete sentences

Select the primary methods of non-verbal communication used:
☐ Facial Expressions ☐ Body Language ☐ Manual sign language
☐ Gestures ☐ Pointing ☐ Eye Gaze

Communication concerns:

Home Environment
Child lives with (select all that apply):
☐ Birth mother ☐ Birth father ☐ Adoptive mother ☐ Adoptive father
☐ Step mother ☐ Step father ☐ Grandmother ☐ Grandfather
☐ Siblings (Please list sibling ages:_________________)
☐ Other relatives (Please specify:________________________) ☐ Legal guardian (Please specify: ___________________________)

Adoption
Age of child at adoption: _________
Please provide additional details of adoption (e.g. country, child's prior living situation, etc.):

Type of home:
☐ Single level home ☐ 2 level home ☐ Ground floor apartment ☐ Upper level apartment
☐ Assisted living facility ☐ Skilled nursing facility ☐ Group home ☐ Other:___________________

Accessibility:

Stairs to get into home? ☐ Yes ☐ No How many?________ Handrail? ☐ Yes ☐ No
Ramp to get into home? ☐ Yes ☐ No
Stairs in home? ☐ Yes ☐ No How many?________ Handrail? ☐ Yes ☐ No

☐ Bathroom on main level ☐ Bathroom on upper level ☐ Bedroom on main level ☐ Bedroom on upper level

Equipment				
	Approx. Age of Equipment	**Details**	**Used at home? (Y/N)**	**Used at school/ daycare? (Y/N)**
Braces				
Walker				
Stander				
Manual wheelchair				
Power wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splint(s)				
Track System				
Other:				

Do you currently perform a home program with the child? ☐ Yes ☐ No
If yes, please describe what you do:

Is the child involved in any community groups or sports activities? ☐ Yes ☐ No
If yes, please provide details:

Grade in school:__________ Where:____
Does your child have an IFSP? ☐ Yes ☐ No
Does your child have an IEP from school? ☐ Yes ☐ No
Has your child had a psychological or neuropsychological evaluation completed? ☐ Yes ☐ No

Other Services				
	Type (Group or Individual)	Status (Ongoing, discontinued, not started)	How often	Where (home, school, day care, outpatient, hospital, other)
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental Therapy				
ECI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Work				
Speech/Language Therapy				
Developmental Follow Up Clinic				
Other:				

Comments: