CONDITION AND HISTORY

Client Name: _____ Date of Birth: _____

Diagnosis/Condition: _____ Date of Onset: _____

Describe your current concerns: _____

_____

_____

When did you become concerned about your child? _____

Has or is your child receiving therapy services? If so, where, from whom, and how long?

_____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Specialists: _____ Phone: _____

Specialists: _____ Phone: _____

School/Program:_____ Phone:_____

School Therapists: _____ Times per week:_____

Do you have an attorney or advocate?……. **Yes** **No**

Does your child have an IEP/IFSP/504 Consult?…….. **Yes** **No**

Prenatal & Birth History: _____

_____

_____

Prior Hospitalizations/Surgeries: _____

_____

Medications: _____

Allergies: _____

Equipment / Vendor: _____

Developmental Milestones (please indicate the approximate age when the child achieved the following):

Rolling _____ Sitting _____ Crawling _____

Riding Bike/Trike _____ Talking (mama/papa) _____ Toilet Training _____

Walking _____ Talking (short sentences)_____ Standing _____

Throwing _____ Running _____

First school experiences:_____

_____

Present school experiences: _____

_____

Describe your child's general behavior at home related to moods, independence, transitions, engagement, responsiveness, frustration, management and response to discipline, etc.

_____

_____

Describe your child's play time activities, including toys he/she prefers or avoids:

_____

_____

Does your child react adversely to touch, smell, movement, heights? If yes, please explain:

_____

Number of siblings _____ What number is you child _____

Does your child have any difficulty with any of the following? If so, describe briefly.

* tolerating noises Yes No Sometimes_____

* tolerating light Yes No Sometimes _____

* sleeping Yes No Sometimes _____

* tolerating clothing Yes No Sometimes _____

* bathing (including hair washing) Yes No Sometimes _____

* swimming -- Describe level _____

* stairs Yes No Sometimes _____

* bike riding -- describe the highest level of riding toy achieved _____

* playing with children the same age Yes No Sometimes _____

* dealing with crowds Yes No Sometimes_____

* following several instructions Yes No Sometimes _____

* trying or learning new games or activities Yes No Sometimes _____

* novel foods Yes No Sometimes _____

* novel experiences Yes No Sometimes _____

* separation from parents/siblings Yes No Sometimes _____

* tantrums Yes No Sometimes _____

* transitions Yes No Sometimes _____

* other _____

In an effort to provide the most effective therapy services, please list what are the areas of function that you would like to see change in your child over the course of therapy. In other words, let's assume that therapy is over and you are deciding whether treatment was successful. What are the improvements that would make you say "Yes, that was worth the time, money and effort we put into it?"

_____

_____

Is there anything you feel we should know that we have not asked? If yes, please explain:

_____

_____