Children's Therapy and Rehab Specialists

Child History Form

Today's Date:_____Completed by: _____

Child's Name:_____ Date of Birth: _____ Age:_____
Parents/Guardians full names:_____ SS#:_____
Address:_____City:_____State:_____Zip:_____
Home Phone: (_____)_____ Cell phone:(_____)_____

In case of emergency, if you can not be reached at home, we can contact:
Name: _____ Relationship:_____
Address: _____City: _____State:_____Zip:_____
Home Phone:(_____)_____ Cell phone:(_____)_____

Primary Physician: _____Phone:(____)_____
Address:_____
Please list on back or separate sheet of paper, any specialists that your child has seen (neurologist, orthopedist, optometrist, etc.): _____
_____

Insurance Information:
Company:_____Insured:_____DOB_____
ID#_____Grp#:_____
Is there a second insurance? If so what company?_____
ID#:_____Grp#:_____
Insured Name and date of birth:_____

Medical Diagnosis: _____

Reason for Referral: _____
_____

Birth Information:
Complications/Health problems with mother during pregnancy: (if yes please explain)
_____
Gestational age (length of pregnancy):_____ birth weight:_____ Apgar scores:_____
Type of delivery: vaginal_____ C-section_____ breech_____ forceps_____ other_____
Complications following delivery: Jaundice____ Breathing____ Heart problems____ Seizures_____
Poor Suck____ Other:_____
Infants length of hospital stay:_____ NICU length of stay:_____

Child's Health and Medical History:
Pneumonia:_____ Reflux:_____ Allergies:_____ Chicken Pox:_____Seizures:_____ (Please describe and indicate frequency of seizures):_____
Ear infections:_____ Frequency/last ear infection:_____
General Health:_____
List any food allergies:_____
Family medical history significant to your child?_____
What family member? Mom__Dad__Grandma__Grandpa__Aunt__Uncle__other:_____

Medical Procedures/Medications: (Please list dates if applicable)
Ear Tubes:_____Still in place?_____ Trach:_____ G-tube:_____Shunt:_____
Tonsillectomy:_____ Heart Surgery?_____ Type:_____
Other_____
Please list any current medications and reason for use: _____
_____

Developmental Milestones:
Please list the ages that your child reached the following developmental milestones:
Lift head when on stomach_____ Roll over _____ Sit without support_____ Crawl _____
Stand alone_____ Walk _____Dress/undress self_____ Button/zip clothes_____
Started solid foods_____ Held cup_____ Used spoon_____ Hand preference _L___R_
Dry during day_____ Dry at night _____ Gain bowel control_____
Does your child have any bowel or bladder difficulties? Please describe_____

Speech:
Please list the ages that your child achieved the following:
Babbling (baba, dada, etc.:)_____ First words: _____ Combined Words:_____
Does your child imitate sounds and/or words: _____
Describe your child's overall speech currently: _____
Does your child respond to speech (their name, directions, etc.):_____
Do you frequently have to repeat directions: _____
What are your greatest concerns about your child's speech and language:_____
_____
_____

Gross Motor:
Describe position(s) your child spends time in at home (held, on stomach/back, sitting, etc.: _____
_____
Describe how your child moves around the house:_____
Describe any atypical motor movements:_____
Does your child fall or lose balance easily:_____
What are your greatest concerns about your child's gross motor skills:_____
_____
_____

Fine Motor & Sensory Processing:

Does your child have any difficulty using their hands to play or manipulate objects:_____

_____

Describe activities your child activities your child enjoys most at home:_____

_____

Describe your child's overall attention span:_____

_____

Describe your child's interaction with toys/objects:_____

_____

Describe your child's independence with "self-care" tasks (dressing, feeding, etc.):_____

_____

_____

Describe your child reactions to "sensory input" (touch, noise, visual, movement, etc.): _____

What are your greatest concerns about your child's fine motor and sensory processing skills:_____

_____

_____

Previous Therapy/Intervention:

Please list any services received in the past _____

_____

_____

Social/Behavioral:

Please describe the things you love most about your child: _____

_____

_____

Please describe what concerns you most about your child: _____

_____

_____

How does your child calm him/herself: _____

_____

How does your child interact in social/group settings:_____

_____

Describe your child's communication with peers: _____

_____

Is a second language spoken at home:_____

How many siblings in the family, please list if brother or sister and ages:_____

_____

_____

_____

General:

Are there any foods that your child is not allowed to have? Please list:_____

_____

_____

_____

May the therapist use food as a therapy tool if appropriate:_____

Is your child allowed to have lollipops or candy?_____

Please describe your discipline approach in the home: (i.e. redirection, positive reinforcement, tine-out, etc)_____

_____

Please describe what best motivates and/or reinforces your child's behavioral: (i.e. specific activities, toys, stickers, rewards, etc):_____

_____

_____

Please indicate what methods the therapist may use to manage your child's behavior during therapy sessions:

a. verbal redirection to a task
b. hand-over-hand guidance through activity
c. reinforcement with stickers
d. reinforcement with candy (lollipops)
e. "time-out"

School District your child attends:_____

Teacher Name and School Phone Number:_____

Any therapy at school? If so what: speech:_____occupational:_____physical therapy:_____

Name of therapists and phone number:_____

Explain what you expect from this evaluation. Identify main concerns and what other information or references would help you most:

_____

_____

_____

HOW DID YOU HEAR ABOUT US? Doctor (name)_____ or mark X on any of the following that applies:

Internet____ Phone book____ Friend____ Drive by____ Ins. Co.____ Other____

Explain other:_____

Thank you for taking the time to complete this history form. The information received in this form is confidential information and intended for our use only unless otherwise authorized by you, the parents or legal guardians. The information will help provide the most efficient and accurate evaluation possible. If there are any questions pertaining to this history form, or more specific concerns about your child, please do not hesitate to discuss this with your child's therapist at Children's Therapy and Rehab Specialists. Our goal is to provide you with the most concise and comprehensive evaluation and treatment plan possible. Again, thank you for your time and effort in completing this form.

CHILDREN'S THERAPY AND REHAB SPECIALISTS

Parent/Guardian Signature **Date**