Evaluation History

Child's Name:	
Date of Birth:	
Referring Physician:	
Reason for Referral:	
Diagnosis (list all):	
Date of injury/date of onset:	
Dominant hand:	(circle one) Right / Left
Dominant foot:	(circle one) Right / Left

Current Concerns:

Please describe the concerns that led you to seek out treatment today: _____

_____

Is there any family history of similar or related concerns? ☐ Yes ☐ No

- If yes, please explain: _____

List **ALL** other providers who you have seen for this concern: _____

_____

Does your child have difficulty keeping up with peers? ☐ Yes ☐ No

- If yes, please explain: _____

Please indicate what symptoms, if any, your child is experiencing at this time:

☐ Weakness	☐ Swelling	☐ Inability to follow directions
☐ Fatigue	☐ Stiffness	☐ Inability to complete routine tasks
☐ Decreased balance	☐ Low muscle tone	☐ Difficulty in school
☐ Coordination difficulties	☐ High muscle tone	☐ Difficulty with feeding
☐ Gait abnormalities	☐ Changes to sensation	☐ Stuttering
☐ Postural abnormalities	☐ Numbness/tingling	☐ Articulation errors
☐ Falling down	☐ Poor attention	☐ Difficulty using language
☐ Pain	☐ Poor awareness of body	☐ Difficulty understanding language

Have your child's symptoms gotten better or worse over time? ☐ Better ☐ Worse

Have you tried anything to help manage the child's symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Medical History:

Please list all Doctors/specialists who follow your child: _____

_____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever had a surgery? ☐ Yes ☐ No

- If yes, please list type & date: _____

Is your child currently taking any medications? ☐ Yes ☐ No

- If yes, please explain: _____

Does your child have any medical precautions? (allergies, history of seizures, etc.) ☐ Yes ☐ No

- If yes, please explain: _____

Has your child had a vision screening? ☐ Yes ☐ No Date: _____ Results: _____
Has your child had a hearing screening? ☐ Yes ☐ No Date: _____ Results: _____
Do you have any concerns regarding your child's feeding or swallowing? ☐ Yes ☐ No
If yes, please explain: _____
Does your child have difficulty falling asleep? ☐ Yes ☐ No
If yes, please explain: _____
Does your child have difficulty staying asleep? ☐ Yes ☐ No
If yes, please explain: _____
Would you describe your child as a picky eater for his/her age? ☐ Yes ☐ No
If yes, please explain: _____

Is your child currently receiving other therapy services OR have they received any in the past? ☐ Yes ☐ No
Check all that apply:

Occupational Therapy:	☐ Past	☐ Present	Date(s): _____
Speech Therapy:	☐ Past	☐ Present	Date(s): _____
Physical Therapy:	☐ Past	☐ Present	Date(s): _____
Psychological Services:	☐ Past	☐ Present	Date(s): _____
School-Based Therapy:	☐ Past	☐ Present	Date(s): _____
Music Therapy:	☐ Past	☐ Present	Date(s): _____
Other: _____	☐ Past	☐ Present	Date(s): _____

If your child is currently receiving school-based services? ☐ Yes ☐ No
****If yes, please provide us with a copy of your child's IEP****
Please list school-bases services and their frequency: _____
_____
_____

Birth History:
Where there any pre or post term complications? ☐ Yes ☐ No
If yes, please explain: _____
☐ Premature Birth ☐ Full-Term Birth ☐ Post-Term Birth My child was born at _____ weeks.
Is the child a multiple (twin, triplet)? ☐ Yes ☐ No Birth Weight: _____
Delivery Type (check all that apply): ☐ Vaginal ☐ Cesarean ☐ Forceps ☐ Vacuum
Did your child have an extended hospital stay after birth? ☐ NICU ☐ Special Care Nursery
If yes, for how long? _____

Social History:
Who lives in the household with the child? _____
Please list name/age(s) of siblings: _____
What is the primary language spoken in the home? ☐ English ☐ Other _____
Does your child attend school or daycare? ☐ Yes ☐ No ☐ Full-time ☐ Part-time
Name of school/daycare: _____ Grade attending: _____
What activities does your child enjoy? _____
What activities does your child not enjoy? _____

Developmental History:
At what age did your child complete the following:

Sitting:	Crawling:	Walking:
Used single words (ex. "bye", "car"):	Used 2-word phrases: (ex. "Ma-ma go"):	