Name: _____ Date: _____

occupational - physical - speech/language therapy
for pediatrics

General Information

Child's Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

☐ Parent(s) ☐ Guardian ☐ Foster Parent(s): _____

Address (Street, City, State, Zip): _____

_____ County: _____ Child's SSN: _____

Home Telephone: _____ Work : _____ Mobile: _____

Emergency Phone: _____ Contact Person: _____

Who referred you to our program? Name: _____ Relationship: _____

Referring Physician: _____ Address: _____ Phone: _____

Reason for Referral: _____ Child's age when problems first noticed: ____

Diagnosis: _____

Pediatrician/Primary Care Physician: _____

Address: _____ Phone: _____

Other physicians your child sees:

1: _____ Specialty: _____ Phone: _____

2: _____ Specialty: _____ Phone: _____

3: _____ Specialty: _____ Phone: _____

Payor Type: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Private Pay ☐ Other

Primary Insurance Company: _____

Address: _____

Policy Holder: _____ Policy #: _____

Date of Birth: _____ SSN: _____ Employer: _____

Secondary Insurance Company: _____

Address: _____

Policy Holder: _____ Policy #: _____

Date of Birth: _____ SSN: _____ Employer: _____

Medicaid #: _____ Georgia Peach Care #: _____

Name: _____ Date: _____

Family Information

Mother's Occupation: _____ Father's Occupation: _____

What language(s) are spoken at home? ☐ English ☐ Spanish ☐ other: _____

Caregiver(s) with whom the child currently resides: _____

Marital status of caregiver: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

How has your child's problem affected your family? _____

_____

List all people now living in the household, including siblings, relatives, friends, etc.:

Name	Relationship to Child	Age	Speech, hearing, motor, academic or behavioral problems

Health Information

Immunization Status: ☐ Up-to-date Reason, if not up-to-date: _____

List concerns about your child's health: _____

List any limitations of precautions due to medical reasons: _____

List all current medications:

Medication	Reason	Medication	Reason

Respiratory status: ☐ Tracheostomy ☐ Oxygen ☐ CPAP

☐ Speaking valve type: _____ ☐ other: _____

List your child's vision problems: _____ When tested? _____

List your child's dental problems: _____

Please check any conditions that apply to your child's medical history:

☐ choking while eating/drinking
☐ head injuries/concussion
☐ craniofacial deformities
☐ fevers over 104 degrees
☐ cleft lip / palate
☐ cerebral hemorrhage
☐ loud voice
☐ meningitis
☐ frequent colds
☐ vocal nodules
☐ breathes with mouth open (☐ day ☐ night)
☐ bronchopulmonary dysplsia
☐ *Myelomennigocele*
☐ heart problems
☐ adenoidectomy
☐ pneumonia
☐ bleeding disorder
☐ sinus infection
☐ hyperactivity
☐ anemia
☐ asthma
☐ reflux
☐ mumps
☐ hoarse voice
☐ tracheotomy
☐ ear tubes
☐ scarlet fever
☐ encephalitis
☐ ear infections
☐ snoring
☐ anemia
☐ diabetes
☐ bronchitis
☐ breathy voice
☐ soft voice
☐ seizures
☐ ear surgery
☐ throat surgery
☐ tonsillectomy

Please describe any medical problems:

_____

_____

Name: _____ Date: _____

Please list any operations, injuries, special tests (MRI, EEG, Swallow Study, etc.):

Operation	Date	Location

List special equipment your child requires: _____

List allergies to: Food: _____ **Non-citrus fruits**: _____

Medications: _____

Check box if allergic to: ☐ molds ☐ pollen ☐ pets ☐ dust ☐ **latex**

Pregnancy and Birth History

Did mother have: ☐ accidents ☐ high blood pressure ☐ other issues: _____

Medications taken during pregnancy: _____

Alcohol, drug or tobacco use during pregnancy? ☐ yes ☐ no Describe: _____

Was child born: ☐ on time ☐ early ☐ late How many weeks? _____

☐ C-Section ☐ Breech delivery ☐ Forceps used

Describe any birth process problems: _____

Birth Weight: _____ Did infant require oxygen? ___ If yes, how long? _____

Was your child in the Neonatal Intensive Care Unit? ___ How long? _____

Was your child jaundiced at birth? ___ How long? _____

Describe any problems noted after birth: _____

Was child released from hospital with mother? ___ When? _____

Did child have problems: ☐ sucking ☐ swallowing ☐ choking ☐ breathing

When held, your baby seemed: ☐ cuddly ☐ irritable

Describe any health/feeding problems during child's first weeks: _____

_____

Feeding Information

Current diet type: ☐ liquids ☐ puree ☐ chopped ☐ regular ☐ other: _____

How does your child eat or drink? ☐ breast-fed ☐ bottle (nipple type: _____)

☐ sippy cup ☐ spoon/fork ☐ cup ☐ feeding tube (type: _____)

Describe any feeding/swallowing problems: _____

Speech and Language Development Information

Describe any concerns about your child's speech, language, or hearing skills: _____

_____

_____

Did your child coo/babble during the first 6-9 months? ___ Age when child began talking: _____

First word(s): _____

Check all that your child understands: ☐ simple commands ☐ simple questions

☐ 2-step directions ☐ 3-step directions

Name: _____ Date: _____

Your child makes his/her needs known by: ☐ speaking ☐ grunting ☐ pointing ☐ gesture ☐ other: _____

Check all that describe your child's current communication:

☐ uses jargon (unrecognizable words that sound like speech)
☐ uses babbling (sound repetitions like baba, dada)
☐ uses 2-word phrases ☐ uses 3 to 4-word phrases ☐ uses 10-15 words
☐ uses conversation ☐ uses complete sentences ☐ asks questions
☐ retells simple stories ☐ repeats nursery rhymes ☐ other: _____
☐ uses 1-5 words
☐ uses 5-10 words

Child asks questions that start with: ☐ who ☐ what ☐ when ☐ where ☐ why ☐ how

Does your child hesitate or repeat sounds/words when talking? ___ Describe: _____

List sounds your child makes incorrectly: _____

Is your child aware of any speech problems? ___ Describe: _____

Motor and Behavioral Information

At what age did your child:

_____	lift head while on tummy	_____	roll over	_____	belly crawl	_____	crawl on all fours
_____	walk holding onto furniture	_____	stand alone	_____	walk alone	_____	reach for toys
_____	drink from a cup alone	_____	finger-feed self	_____	use spoon	_____	begin spoon foods
_____	be toilet-trained while awake	_____	give up pacifier	_____	stop bottle	_____	stop breastfeeding

What is your child's primary way of getting around? _____

Can your child: ☐ catch a ball ☐ kick a ball ☐ throw a ball? How accurate? _____

Can your child: ☐ jump ☐ run ☐ balance on one foot ☐ ride a bike?

Is your child: ☐ right-handed ☐ left-handed ☐ not yet established?

My child has trouble with: ☐ holding toys ☐ holding a pencil/crayon ☐ forks ☐ spoons ☐ puzzles/manipulative toys ☐ scissors ☐ writing

Does your child dress/undress independently? ___ If not, what help is needed? _____

List any concerns about your child's motor, attention or play skills: _____

_____

Compared to children of the same age, my child is: ☐ more coordinated ☐ more clumsy ☐ does things differently ☐ does not do things as easily

Does your child have difficulty learning new skills/games? _____

What games/playground equipment/activities/toys does your child dislike? _____

What activities does your child like? _____

My child is unusually sensitive to having: ☐ hair washed ☐ face washed ☐ body washed ☐ teeth brushed ☐ nails trimmed ☐ clothing tags ☐ spinning ☐ loud noises ☐ hugged by family member ☐ other: _____

Other than TV, how long can your child attend to a favorite play activity? _____

How long can your child attend to a difficult task? _____

Does your child play well with other children his/her age? _____

Name: _____ Date: _____

My child seeks out: ☐ rocking ☐ twirling ☐ jumping ☐ biting ☐ climbing
☐ spinning ☐ mouthing toys ☐ repetitive activities ☐ head banging

My child seems: ☐ clumsy ☐ insensitive to pain ☐ distracted by lights
☐ easily frustrated ☐ aggressive

Describe your child's discipline problems: _____

What does your child do when angry or frustrated? _____

List your child's unusual fears, if any: _____

Are you able to do structured home program activities with your child? ☐ yes ☐ no

If yes, how much time will you have to work with your child? _____

Education and Therapy Information

Does your child currently receive Early Intervention Services (Babies Can't Wait)? ☐ yes ☐ no

Service Coordinator: _____

What are your child's current school hours? _____ Teacher: _____

The teacher describes your child's performance as: _____

List all daycare and school experiences:

School Name	Dates Attended	Placement / Grade / Regular or Special Class

Does your child read? ☐ yes ☐ no Reading grade level, if known: _____

List any resource services received: _____

Describe any problems your child has had in school: _____

Has your child received any previous evaluations or therapy for speech, hearing, physical, occupational, learning or behavioral problems? ☐ yes ☐ no

If yes, list the following information:

Date Started	Date Ended	Agency	Location

Please add any additional comments or concerns about your child: _____

_____

Do you need any help with funding, respite care, community programs, transportation, or other concerns?

_____

Date: _____ Signature: _____ Relationship: _____

Name: _____ Date: _____

What are your expectations and goals for this evaluation/therapy?

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Please bring copies of previous evaluations with you or have reports sent to us at: 304 E. 6th Ave. Rome, GA 30161