Children's Therapy Center

Helping children achieve their fullest potential

Client Information:

Client Name:_____ Date of Birth: _____Age:_____

Other Services Child is Receiving:_____

Service Coordinator/Referred By :_____

Reason For Referral:_____

Medical Information:

Approximate date of last complete physical examination:_____

Approximate date of last eye examination:_____ By Whom:_____

Approximate date of last hearing examination:_____By Whom:_____

What were the findings of these examinations? _____

_____

Please list any medication your child is presently taking and the reason for the medication:_____

_____

Does your child have any allergies? _____If so please list them:_____

Has your child experienced frequent colds, ear infections, or other illnesses? Please explain:

_____

_____

Has your child had any serious illnesses, high fevers, convulsions, hospitalizations, or mild head traumas? Please explain:

_____

_____

Pregnancy History:

This is my: Natural born child_____ Adopted child_____ Foster child_____

Were there any complications experienced during pregnancy, labor, or delivery? Please explain:

_____

_____

Was the mother exposed to, or did she experience any of the following, during pregnancy?

_____Rubella _____Kidney Disease

_____Measles _____Thyroid Disease

_____Diabetes _____Heart Disease

_____Toxemia _____Bleeding

_____Other (explain):_____

Child's Birth History:

Was the child delivered full term or premature? _____How early? _____

Type of delivery: Vaginal _____ C-Section_____

If C-Section please state the reason:

_____

_____

Did the baby have any difficulty breathing? _____

If vaginal delivery, did baby present: Breech (feet first) ____

Transverse (Sideways) ____

Face presentation ____

Baby's birth weight: _____Apgar score at: 1 minute: _____5 minutes_____

1) Did mother have any shocks or unusual stress during pregnancy?
   Yes___No___ If yes, please explain:_____
2) Water break more than 24 hours before delivery? Yes___No___
3) Develop toxemia/high blood pressure during pregnancy? Yes___No___
4) Mothers age at delivery? _____

Was or did the child:	Yes	No
1) Have cord wrapped around neck	___	___
2) Require forceps	___	___
3) Have birth injuries	___	___
Please explain:_____		
4) Require a fetal monitor	___	___
5) Experience insufficient oxygen	___	___
6) Cry right away	___	___
7) Need intensive care hospitalization?	___	___
a. How long_____		
b. Pre-maturity	___	___
c. Respiratory problems	___	___
d. Need respirator	___	___
e. Small for gestational age	___	___
f. Have a heart defect	___	___
g. Need transfusion	___	___
h. Jaundiced	___	___
i. Have congenital abnormalities	___	___
j. Have seizures	___	___
k. Have infection at birth	___	___
l. Have surgery as a newborn	___	___
m. Have feeding problems as a newborn	___	___

Child's Developmental History:

At what age did your child?

_____Roll	_____Sit	_____Dress self
_____Crawl	_____Pull to stand	_____Use silverware
_____Stand Alone	_____Walk	_____Tie shoes
_____Say first word	_____Say first sentence	_____Feed self

How old was your child when s/he was toilet trained for day? _____Night? _____

Which hand does your child prefer using, and at what age did that preference develop? _____

_____

Please list the areas of concern you have regarding your child's development: _____

_____

_____

_____

Please note your child's strengths:_____

_____

_ _____

_____

Please state your goals for your child. These may include things that you would like your child to learn to do better or feel more comfortable while doing-List goal and Priority.

GOAL PRIORITY

_____

_____

_____

_____