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| **GENERAL HISTORY** |
| Name:Click here to enter text. | DOB:Click here to enter text. | Date:Click here to enter text. |
| Siblings Names and Ages:Click here to enter text. |
| Living Situation – Any recent changes:Click here to enter text. |
| Is your child adopted or in foster care with you? Describe previous home experiences:Click here to enter text. |
| When did you first become concerned about your child’s development? What are your concerns for him/her?Click here to enter text. |
| What do you see as your child’s strengths? Click here to enter text. |
| At what age did your child achieve these milestones? |
| Sitting Alone | Click here to enter text. | Crawling | Click here to enter text. | Walking | Click here to enter text. |
| Babble | Click here to enter text. | First Word | Click here to enter text. | Combined Words | Click here to enter text. |
| Drink from a cup | Click here to enter text. | Chew Solid Food | Click here to enter text. | Spoke in sentences | Click here to enter text. |
| **MEDICAL HISTORY** |
| Describe if mother had any illnesses or complications during pregnancy or delivery?Click here to enter text. |
| Birth Weight: | Click here to enter text. | Length: | Click here to enter text. | Number of weeks of birth gestation: | Click here to enter text. |
| Vision – Tested? | [ ] Yes [ ] No | Results: | Click here to enter text. | Corrective Lenses? | [ ] Yes [ ] No |
| Hearing – Tested? | [ ] Yes [ ] No | Results: | Click here to enter text. | Ear Infections? | [ ] Yes [ ] No |
| Feeding – Describe if your child had any feeding problems as an infant:Click here to enter text. |
| Breastfed? | [ ] Yes [ ] No | How long? | Click here to enter text. | Bottle fed? | [ ] Yes [ ] No | How long? | Click here to enter text. |
| Describe if your child had colic or reflux as an infant: Click here to enter text. |
| Medical conditions/surgery:Click here to enter text. |
| Medication(include vitamins, prescriptions, OTC or homeopathic med):Click here to enter text. |
| Allergies: Click here to enter text. |
| Food Intolerances: Click here to enter text. |
| **CHILD INFORMATION** |
| Please describe your child’s personality: Click here to enter text. |
| How do you discipline issues at home? Click here to enter text. |
| Does your child have tantrums? [ ] Yes [ ]  No | If “YES” – How often? Click here to enter text. |
| Describe how your child handles changes to routine: Click here to enter text. |
| Describe your child’s eating habits: Click here to enter text. |
| Describe your child’s sleeping habits/patterns: Click here to enter text. |
| Describe your child’s toilet training history: Click here to enter text. |
| Describe your child’s ability for dressing, bathing and grooming: Click here to enter text. |
| Language(s) spoken in the home: Click here to enter text. |
| How does your child make wants known? Click here to enter text. |
| Which sounds do you notice being correctly produced? Click here to enter text. |
| How many words does your child use? Click here to enter text. |
| How long are your child’s sentences? Click here to enter text. |
| Does your child have any difficulty understanding you? (Describe): Click here to enter text. |
| Does your child have any difficulty following directions? (Describe): Click here to enter text. |
| Are there are speech or hearing problems in the immediate or extended family? (Explain): Click here to enter text. |
| How well is your child understood by: (i.e. what percentage of the time) |
| Mom | Click here to enter text. | Dad | Click here to enter text. | Younger siblings | Click here to enter text. |
| Older siblings | Click here to enter text. | Extended family | Click here to enter text. | Unfamiliar adults | Click here to enter text. |
| Describe what it is like to have a conversation with your child: Click here to enter text. |
| What are your goals for therapy intervention for your child? Click here to enter text. |