

Child's Name: _____

Pregnancy / Delivery

- Pregnancy Proceeded Without Complications
 With Complications
- | | |
|---|---|
| <input type="checkbox"/> Eclampsia | <input type="checkbox"/> Positive for Strep B |
| <input type="checkbox"/> Medications During Pregnancy | <input type="checkbox"/> Pre-eclampsia |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Premature Labor |
| <input type="checkbox"/> Multiple Births | <input type="checkbox"/> Substance Exposure |
| <input type="checkbox"/> Positive for Cytomegalovirus | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Positive for Herpes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Positive for HIV | |

Length of Pregnancy (in weeks) _____ Prenatal care was Received Not Received

Mother's age at time of birth: _____

- Delivery Proceeded Without Complications
 With Complications
- | | |
|---|---|
| <input type="checkbox"/> Abruptio Placenta | <input type="checkbox"/> Prolapsed Cord |
| <input type="checkbox"/> Breech Presentation | <input type="checkbox"/> Transverse Presentation |
| <input type="checkbox"/> Negative Vacuum | <input type="checkbox"/> Umbilical Cord Wrapped Around Neck |
| <input type="checkbox"/> Placenta Previa | <input type="checkbox"/> Use of Forceps |
| <input type="checkbox"/> Premature Rupture of Membranes | <input type="checkbox"/> Uterine Rupture |
| | <input type="checkbox"/> Other: _____ |

Delivery was: Vaginal C-section Emergency C-section Days in Hospital: _____

Birth Weight: _____ Birth Height: _____

Reason for C-section (if applicable): _____

Following Birth

Complications Following Birth

- No Yes Reports as unremarkable? (If yes, please mark all that apply below.)
- | | |
|---|--|
| <input type="checkbox"/> Anemia of Prematurity | <input type="checkbox"/> IVG Bleed Grade IV: L R (Circle Side) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Meconium Aspiration |
| <input type="checkbox"/> Brohopulmonary Dyspasia 'BPD' | <input type="checkbox"/> Necrotizing Enterocolitis 'NEC' |
| <input type="checkbox"/> Cleft Lip | <input type="checkbox"/> Neonatal hypoxia |
| <input type="checkbox"/> Cleft Palate | <input type="checkbox"/> NICU Stay |
| <input type="checkbox"/> Club Foot | <input type="checkbox"/> Oxygen dependency |
| <input type="checkbox"/> Cytomegalovirus | <input type="checkbox"/> PDA - Surgery for Heart Valve |
| <input type="checkbox"/> ECMO | <input type="checkbox"/> Positive dependency |
| <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Respiratory Distress Syndrome |
| <input type="checkbox"/> History of Intubation | <input type="checkbox"/> Respiratory Stridor |
| <input type="checkbox"/> History of Pneumonia | <input type="checkbox"/> Respiratory Syncytial Virus 'RSV' |
| <input type="checkbox"/> Hyperbilirubinemia | <input type="checkbox"/> Retinopathy of Prematurity 'ROP' |
| <input type="checkbox"/> Intrauterine Growth Retardation 'IUGR' | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> IVH Bleed Grade I: L R (Circle Side) | <input type="checkbox"/> Ventilator Dependency |
| <input type="checkbox"/> IVH Bleed Grade II: L R (Circle Side) | <input type="checkbox"/> VP Shunt |
| <input type="checkbox"/> IVH Bleed Grade III: L R (Circle Side) | <input type="checkbox"/> Other |

If applicable, your reason for referral (What are your concerns?):

Health Issues

- No Yes Reports as unremarkable? (If yes, please mark all that apply below.)
- Anoxic Brain Injury
 - Arteriovenous Malformation 'AVM'
 - Asthma/Respiratory
 - Cerebral Vascular Accident 'CVA'
 - Chronic Ear Infections
 - Colic
 - Other
 - Constipation
 - Cytomegalovirus (CMV)
 - Reflux
 - Seizure Disorder
 - Sleep Problems
 - Traumatic Brain Injury
 - Tube Feeding

Allergies: _____

Current Medications: _____

Current Vitamins, Herbs, Minerals, Homeopathics, etc: _____

Hearing Test

- Never Tested, No Concerns
- Never Tested, Have Concerns
- Normal Test Results
- Abnormal Test Results

Test Date: _____

Results: Hearing Aids PE Tubes
 Bilateral Cochlear Implant

Concerns: _____

Other

Vision Test

- Never Tested, No Concerns
- Never Tested, Have Concerns
- Normal Test Results
- Abnormal Test Results

Test Date: _____

Results: Wear Glasses
 Other: _____

Concerns: _____

Other

Specialists Seen

Specialist	Name	Reason
Allergist		
Audiologist		
Cardiologist		
Developmental Medicine		
Endocrinologist		
ENT		
Gastroenterologist		
General Surgeon		
Geneticist		
Hand Surgeon		
Internal Medicine		
Nephrologist		
Neurologist		
Oncologist		
Ophthalmologist		
Orthopedic Surgeon		
Pediatrician		
Podiatrist		
Psychiatrist/Psychologist		
Rheumatologist		
Thoracic Surgeon		
Urologist		
Family Therapy		
Other		

Diagnostic Tests

Test	When	Results
ABR/BAER		
Blood Work / Lab Tests		
Bone Density Scan		
CT Scan		
EEG		
EMG		
Lower GI		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Upper Endoscopy		
X-Ray		
Other		

Surgeries and Procedures

Type	When	Age	Results

Contraindications / Precautions (Past or Present)

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> hx of Fractures | <input type="checkbox"/> Tube Feeding |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vagal Nerve Stimulator |
| <input type="checkbox"/> Baclofen Pump | <input type="checkbox"/> Seizure Condition | <input type="checkbox"/> None |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> Shunts | <input type="checkbox"/> Other |

Assistive Devices

- Braces
 Location: _____
- Canes
 Walker
 Wheelchair Other

Medical Conditions:

Orthopedic Conditions/Dislocations: _____

Developmental History

Motor / Sensory / Plan

Milestone	When (in months)	Milestone	When (in months)
Creeps / Crawls Alone		Rolls Over	
Grabs Toys		Sits Alone Without Support	
Holds Head Up Alone		Walks Unaided	
Pulls Self to Standing Positions			

How does child get around the house?

Favorite Toys / Play Activities: _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Does child fall or lose balance easily? | Child's Hand Dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Neither |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Child visually looks at people and/or toys? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Child shows a negative response when touched or when touching other objects? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Child enjoys movement such as swinging or roughhousing? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Child plays and/or participates in leisure activities daily? List: _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Child involved in community programs (school, special rec., scouts, etc.?) List: _____ | |

Feeding / Speech / Language

Describe any feeding problems: _____

Food Likes: _____

Food Dislikes: _____

Yes No Does child eat a variety of textures?

Feeding / Speech / Language			
Milestone	When (in months)	Milestone	When (in months)
Begin Eating Baby Food		Name Familiar Objects	
Begin Eating Junior Food		Using a Bottle	
Begin Eating Table Food		Using a Pacifier	
Begin Using A Cup, Sippy Cup, Straw		Use Two-Word Combinations	
Complete Sentences			

Areas of Difficulty

- Chewing Drooling Pronouncing Words Correctly Swallowing Voice Concerns
- Communication Needs Expressing Words Stuttering Transitioning Between Foods (hoarse/harsh voice, etc.)
- Other

Primary Communication

- Non-Verbal
 - Eye Gaze Manual Sign Language Phrases Single Words Other
 - Facial Expressions Pointing / Gesturing Sentences Vocalizations

Augmentative Communication Device: _____

First Words: _____

Description of Child

- Active Cautious Easy to Engage Insecure Playful
- Affectionate Curious Hard to Engage Irritable Shy
- Aggressive Demanding Fearful Motivated Stubborn
- Appropriate Eye Contact Difficult to Comfort Fearless Passive Withdrawn
- Calm Distractible Fussy Persistent Other

Primary Communication

Grade in School: _____ Name of School: _____

- Yes No Does Your Child have an IEP/IFSP from school?
- Yes No Has your child has a psychological or neuropsychological evaluation completed?
- Yes No Does you child recieve therapy in school?
If so, which? _____

Therapy Service	Type	Status	Where	Frequency/Duration
Assistive Technology				
Aquatic Therapy				
Audiology				
Behavior Therapy				
Developmental History				
Hippo Therapy				
Hyperbaric Therapy				
Intensive Therapy				
Intensive Suit Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Therapy				
Speech / Language Therapy				
Vision Therapy				

Please provide any documentation