



INDIVIDUAL HISTORY RECORD

Please complete the following individual history record as it applies to your child

DATE: _____ CHILD'S NAME: _____

E-MAIL ADDRESS: _____ D.O.B.: _____

ADDRESS: _____

PHONE NUMBERS: _____

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE: _____

NAME OF OTHER SPECIALISTS TREATING YOUR CHILD: _____

PARENT'S

MOTHER

FATHER

Name: _____

Profession: _____

Handedness (R or L): _____

PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY

NAME: _____

WORK/CELL NUMBER: _____

Who can we thank for this referral? _____

Please describe the reason for referral / diagnosis: _____

What are your major concerns about your child? _____

ADOPTION: (Complete if appropriate-otherwise proceed to the next session)

Please explain the circumstances surrounding the adoption: _____

Age Adopted: _____

Prior Homes: _____

Response to New Home: _____

Aware of Adoption: _____

PRENATAL HISTORY

History of pregnancy with this child (medications, health of mother, complications, problems): _____

Length of pregnancy (number of weeks): _____

Type of delivery/complications: _____

Previous pregnancies/complications: _____

MEDICAL HISTORY

Hospitalizations right after birth (NICU) length of stay: _____

Other Childhood Hospitalization (reason, age): _____

Childhood illnesses (Check)

Asthma _____	Measles _____	Tubes in Ears _____
Allergies _____	Pneumonia _____	Ear Infections _____
Mumps _____	Chicken pox _____	Frequent Colds _____
Seizures _____		

Any other medical information you feel we should be aware of: _____

Has a **neurologist** seen your child? Yes No

If yes, the Neurologist's name: _____

Results: _____

Has your child's **vision** been tested? Yes No

If yes, the ophthalmologist or optometrist's name: _____

Results: _____

Has your child's **hearing** been tested? Yes No

If yes, the audiologist name: _____

Results: _____

List any **medications** taken regularly: _____

Are there any other illnesses or medical conditions which have been **diagnosed**? _____

Please inform us of any other **therapies** the child receives and the frequency (PT, ST, AVT)? _____

DEVELOPMENTAL HISTORY (Complete **appropriate sections** and proceed to the next session)

Condition of newborn (Apgar scores, weight, height, problems): _____

Feeding as an infant (method, eating patterns, problems): _____

Current eating habits: _____

Sleep (patterns, problems): _____

Activity level (reaction to being moved, degree of activity, child's favorite activity): _____

Toilet training (age, duration, problems): _____

Developmental milestones - Age at which child completed the following:

Rolled _____	sat alone _____	used words _____
drank from a cup _____	crawled _____	2 word sentences _____
dressed self _____	walked _____	3-4 word sentences _____
used spoon _____	ran _____	asked questions _____
used knife _____		

Describe general fine motor and gross motor coordination: _____

Describe ability to communicate: _____

Describe any unusual behaviors or problems (head banging, temper tantrums, rocking, etc.): _____

SELF CARE SKILLS (Complete if appropriate-otherwise proceed to the next session)

Tolerates hygiene activities _____ Undresses self _____ Dresses Self _____ Pants _____
 Shirt _____ Underwear _____ Shoes _____ Socks _____ Fasteners _____ Shoe Laces _____

Eats Independently (fork? Spoon? Knife?): _____
Falls asleep on his/her own _____
Calms Down easily when upset _____

EDUCATIONAL HISTORY (Complete if appropriate-otherwise proceed to the next session)

Preschool (name and age started): _____
Present school and grade: _____
Type of class (structured, open, etc.): _____
Teacher's comments (anything the teacher told you about your child): _____
Comments your child 's teacher had made): _____
Performance at school (behavior, socialization, play patterns): _____
Does your child like school? Yes No Grades (A), (B), (C), (D)
Classes he/she especially likes/dislikes: _____
Check any areas of difficulty or concern for your child:
Reading: _____ Conduct: _____ Completing Work: _____
Math: _____ Phys. Ed.: _____ Playground time: _____
Do you feel your child can organize work adequately? _____
List your concerns regarding school: _____

FAMILY HISTORY

Names, ages and hand dominance of the children in the family:

<u>NAME</u>	<u>AGE</u>	<u>R or L HANDED</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Did any of the children received therapy, special training or schooling? _____
Describe how the child gets along with parents and siblings?: _____

How do you describe your child's **social skills**?: _____

History of the family since the birth of the child (moves, changes, significant traumas, other significant factors): _____

Parents live together?: _____
Describe custody if necessary: _____

ADDITIONAL INFORMATION

Is there any other information you feel would be helpful as we evaluate your child? _____

Any other concerns: _____

What do you hope to learn from this evaluation? _____

Parent **GOALS** for Therapy: _____

The above information is, true and complete to the best of my knowledge.

Parent Signature

Date