QUINCY MEDICAL GROUP
Pediatric Therapy

Date Sent: ______________________

Date Return by: ______________________

Pediatric Therapy
Speech, Occupational, & Physical Therapy History Form
Ages 0-3

For assistance in completing this packet, please call (217) 222-6550, ext. 3255.
Please send completed form to **pediatrictherapyreception@quincymedgroup.com.**

GENERAL INFORMATION

Child's Name: ______________________ Birthdate: ______________________

Date Form Completed: ______________________

Name of Person Completing Form: ______________________

Relationship to Child: ______________________

Are you the child's legal guardian? ☐ YES ☐ NO

List the 3 main concerns that you have about your child? (e.g., behavior concerns, learning concerns, fine motor skills, gross motor skills, talking, etc.)

1. ______________________
2. ______________________
3. ______________________

CURRENT DIAGNOSES

Please list your child's current diagnoses (medical/developmental/psychiatric, if any):

Diagnosis	**Who made this diagnosis?**	**How old was your child when this diagnosis was made?**

Is anyone concerned that your child may have Autism? ☐ YES ☐ NO

DEVELOPMENTAL MILESTONES

At what age did your child do the following?:

	Age	Explain Any Concerns
Labeled objects (e.g., ball, dog, etc.)		
Spoke in 2-3 word phrases (e.g., "Mommy go," "I want it")		
Sat alone without support		
Crawled		
Walked Independently		
Potty trained during the day		
Potty trained at night		

Does your child have difficulty completing the following independently?:

	Yes	No	Explain
Dressing him/herself			
Buttons, snaps, or zippers			
Feed him/herself			
Drinking from an open cup			
Use silverware			

Does your child have difficulty with any of the following:

	Yes	No	Explain
Lifting his/her head or has a preference to rotate head towards one direction (over 2 months of age)			
Pulling to standing or remaining standing (over 8 months of age)			
Rolling (back to stomach - over 4 months of age, stomach to back - over 7 months of age)			
Sitting without support (over 8 months of age)			
Kicking a ball			
Picking up objects off of floor while standing (over 24 months of age)			
Climbing stairs (over 14 months of age)			
Changing positions (e.g., sitting to standing, etc.)			
Frequent falling			
Blanking out/hard to get his/her attention			
Tremors			

	Yes	No	Explain
Using tools (e.g., pencils, scissors)			
Has a dominant hand			
Turning doorknobs/handles/opening and closing items			
Picking up and grasping small objects			
Throwing/catching a ball			
Hypotonia (low muscle tone/floppy body)			
Hypertonia (tight muscle tone)			
Fatigues easily during active play (e.g., sports, gym class, playground, etc.)			
Often “w” sits on the floor			
Hopping on one foot			
Jumping			
Walking on toes			
Walking/running			
Overall coordination (explain)			
Keeps hands fisted and closed most of the time			
Displays motor tics			
Displays vocal tics (e.g., noises)			
Stuttering			
Repetitive motor mannerisms (e.g., hand flapping, finger twisting, etc.)			
Comprehending spoken directions			
Being understood by others when speaking			
Answering “wh” questions (e.g., “What is your name?”)			
Participating in conversation			

Did your child ever have a SIGNIFICANT LOSS of an acquired skill (not just a delay in the skill)?:

	Yes	No	Explain
Social functioning			
Speech/language			
Problem-solving			
Motor coordination			
Bladder/bowel control			

Please mark any of the following sensory concerns that you have about your child:

Sensitive to clothing	☐ Wearing new or stiff clothing ☐ Always has to have tags cut out ☐ Refuses to wear constrictive clothing (turtlenecks, jeans, hats, belts, etc.) ☐ Distressed by seams in socks
Sensitive to touching	☐ Avoids touching certain textures of materials (e.g., blankets, rugs, stuffed animals, vibrating/slippery/slimy toys) ☐ Bothered by certain bed sheets (e.g., has to have specific texture of sheets) ☐ Avoids or dislikes "messy play"/does not want certain textures on his/her hand or body (e.g., sand, mud, water, glue, glitter, play-doh, slime, shaving cream/funny foam, etc.) ☐ May refuse to walk barefoot on grass or sand ☐ Resists being held or cuddled
Difficulty tolerating grooming tasks	☐ Distressed when having face washed or getting water on face ☐ Distressed when having hair cut ☐ Distressed when having toenails/fingernails cut ☐ Distressed when having hair washed (e.g., tipping head backwards) ☐ Not usually aware when hands or face are dirty or feels his/her nose running ☐ Cries inconsolably until a wet or dirty diaper is changed
Craves touch	☐ Constantly touching objects and people ☐ Fidgets frequently ☐ Thoroughly enjoys and seeks out messy play (e.g., sand, mud, glue, etc.) ☐ Shows no distress with shots
Avoids movements	☐ Avoids playground equipment ☐ Avoids rotating movements (e.g., merry-go-rounds or tire swings) ☐ Prefers sedentary activities ☐ Distressed by baby swing, jumping, wagons, or stroller rides ☐ Distressed by certain positions (e.g., being on his/her tummy or back)
Afraid of heights	☐ Afraid of falling ☐ Avoids/dislikes elevators and escalators; may prefer sitting while he/she is on them ☐ Fearful of going up or down stairs or walking on uneven surfaces (e.g., curbs)
Seeks movement	☐ Child seems to move more than other children his/her age ☐ Craves fast, spinning, and/or intense movement experiences ☐ Always jumping on furniture, trampolines, spinning in a swivel chair, or getting into upside down positions ☐ Loves to swing as high as possible and for long periods of time ☐ Is a "thrill-seeker" and is dangerous at times ☐ Has difficulty sitting at the table for meals ☐ Has difficulty sitting to complete activities ☐ Seeks out jumping, bumping, and crashing activities ☐ Usually runs, jumps, and hops when he/she should be walking
Seeks out rough and tough play activities	☐ Constantly jumping and crashing ☐ Frequently falls on floor intentionally ☐ Could jump on a trampoline for hours ☐ Frequently jumps off furniture or from high places ☐ When in a store or at home he/she may seem like a "bull in a china shop"
Seeks out deep pressure	☐ Uses a weighted blanket to sleep ☐ Excessively asks for bear hugs ☐ Prefers clothes (and belts, hoods, shoelaces) to be as tight as possible
Uses too much force	☐ Too rough when playing with peers ☐ Accidentally too rough with animals ☐ Often breaks objects or toys ☐ Stomps when walking ☐ Accidentally slams doors ☐ Presses buttons too hard ☐ Accidentally slams objects down

Sensitive to sounds	☐ Covers ears with loud noises ☐ Distracted by sounds not normally noticed by others (e.g., humming of lights or refrigerators, fans, heaters, or clocks ticking, lawn mowing or outside construction) ☐ Fearful of the sound of a flushing toilet (especially in public bathrooms), vacuum, hairdryer, squeaky shoes, or a dog barking ☐ May refuse to go to movie theaters, parades, skating rinks, parties, musical concerts, etc. because they are too loud ☐ Sensitive to sounds such as pencil tapping, pen clicking, talking, singing, whistling, etc.
Needs auditory repetition	☐ Often does not respond to verbal cues or to name being called ☐ Needs directions repeated often, or will say, "What?" frequently ☐ Talks to self while completing tasks ☐ Makes noises during inappropriate times
Oral sensitivity	☐ Difficulty tolerating tooth brushing ☐ Dislikes or complains about toothpaste and mouthwash ☐ May lick, taste, or chew on inedible objects (e.g., hair, shirt, fingers, shirt sleeves, pens, etc.) ☐ Drools ☐ Loves vibrating toothbrushes ☐ Avoids putting toys in mouth
Olfactory sensitivity	☐ Overly sensitive to smells that do not usually bother or get noticed by others ☐ Refuses to eat certain foods because of their smell ☐ Bothered/irritated by smells (e.g., perfume, cologne, bathroom odors, personal hygiene smells, cleaning products, air fresheners, household, cooking, etc.) ☐ May drink or eat things that are poisonous because he/she does not notice the noxious smell ☐ Does not notice odors that others usually complain about ☐ May sniff toys, objects, people, or places
Visual sensitivities	☐ Sensitive to bright lights; will squint, cover eyes, cry and/or get headaches from the light ☐ Has difficulty keeping eyes focused on activity that he/she is working on for an appropriate amount of time ☐ Easily distracted by other visual stimuli in the room (e.g., movement, decorations, toys, windows, etc.)

DIETARY/NUTRITION/METABOLIC

	Yes	No	Explain
Feeding issues in infancy			
Current feeding issues			
Is the child's nutrition adequate?			
Refuses to eat a variety of foods			
Eats 2 or less types of meats (in a non-vegetarian household)			
Eats 2 or less types of vegetables			
Eats 2 or less types of fruits			
Avoids mixed textures of foods or gags with textured foods			
Will ONLY eat hot foods or ONLY eat cold foods			
Puts non-food items in mouth			
Avoids specific food groups			
Special diet (please explain)			

	Yes	No	Explain
Difficulty with solids (e.g., only eats soft/pureed foods)			
Has difficulty swallowing			
Has difficulty with sucking/chewing/ licking an ice cream cone			
Difficulty drinking liquids			
Dehydration needing hospitalization			
Chokes when eating			
Other eating/drinking concerns			

SOCIAL HISTORY

Caregiver Information

Primary Caregiver #1 Information:

First:__________________________ Middle:__________________________ Last:__________________________________

Address (if different from child's): ____
Number and Street City, State, Zip

Telephone: ____ Cell Phone: ____

Level of Education: ______________________ Age: _______________ Occupation: _____________________________

Name of Employer:____

Caregiver #1's Legal Relationship to child (Check one):

- ☐ Biological Parent
- ☐ Adoptive Parent
- ☐ Step-Parent
- ☐ Foster Parent
- ☐ Other (e.g., grandparent, etc.): ____

Primary Caregiver #2 Information:

First:__________________________ Middle:__________________________ Last:__________________________________

Address (if different from child's): ____
Number and Street City, State, Zip

Telephone: ____ Cell Phone: ____

Level of Education: ______________________ Age: _______________ Occupation: _____________________________

Name of Employer:____

Caregiver #2's Legal Relationship to child (Check one):

- ☐ Biological Parent
- ☐ Adoptive Parent
- ☐ Step-Parent
- ☐ Foster Parent
- ☐ Other (e.g., grandparent, etc.): ______________________________

Child's parent(s) living outside the home:

Name: ______________________________ Relationship: ______________________

Age: __________ Education (years): ________ Occupation: ______________________

Current Living Situation
People living in the same household as the child:

Name	Age	Relationship to Child	Occupation

FAMILY STRESSORS

Please mark any life events for the child/immediate family that have occured within the child's life:

Life Event	Yes	No	Date/Explain
Divorce/separation			
Death of family member/pet/close friend			
Substance abuse			
Caregiver deployment			
Caregiver psychiatric hospitalization			
Caregiver/sibling medical hospitalization			
Significant caregiver travel			
Homelessness			
Domestic violence			
Living in a shelter			
Involvement with DCFS (for child/parent/siblings)			

Life Event	Yes	No	Date/Explain
Parental incarceration during child’s life			
Child involvement with legal system (truancy, stealing, violence, etc.)			
Physical abuse			
Sexual abuse			
Neglect			
Emotional abuse			
Car/other accident			
Fire			
Other natural disaster			
Multiple home moves (list all)			
Other family stressors (please explain)			

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Has anyone in the child’s family had any of the following?:
(e.g., mother, father, sister/brother, grandparent, uncles, aunts, cousins)

	Yes	No	Relationship to Child
Autism Spectrum Disorder			
Fragile X Syndrome			
Tuberous Sclerosis			
Other Genetic/Chromosomal Disorder			
Intellectual Disability			
Learning Disability			
Language Disorder (e.g., speech therapy/ stuttering/late talker)			
Attention-Deficit/Hyperactivity Disorder			
Tourette’s Syndrome			
Seizure Disorder			
Obsessive Compulsive Disorder			
Other Anxiety Disorder			
Depression			
Bipolar Disorder			
Schizophrenia/Psychosis			
Substance Abuse (drug/alcohol abuse)			
Childhood Deaths			
Other Birth Defects (e.g., cleft lip, club foot, etc.)			

	Yes	No	Relationship to Child
Gland/Endocrine Disorders (e.g., thyroid, diabetes, etc.)			
Immune Disorders (e.g., arthritis, lupus, etc.)			
Other			

DEVELOPMENTAL HISTORY

Pregnancy stressors/maternal health during pregnancy:

	Yes	No	Explain
Domestic violence during pregnancy			
Physical abuse/sexual abuse/ emotional abuse during pregnancy			
Other stressors (deployment, unplanned preg-nancy, etc.)			
Homelessness during pregnancy			
Dehydration/hospitalizations for mother			
Serious infections (e.g., flu, measles, etc.)			
Seizures during pregnancy			
Diabetes during pregnancy			
High blood pressure during pregnancy			
Threatened miscarriage/early contractions			
Abnormal results from prenatal screenings			
Other (list)			

Prenatal exposures during pregnancy:

	Yes	No	Trimester	Type/Amount
Smoking			☐ 1 ☐ 2 ☐ 3	
Alcohol			☐ 1 ☐ 2 ☐ 3	
Street drugs			☐ 1 ☐ 2 ☐ 3	
Prescription drugs			☐ 1 ☐ 2 ☐ 3	
Psychiatric mediation (e.g., antidepressants/antianxiety, etc.)			☐ 1 ☐ 2 ☐ 3	
Prenatal vitamin			☐ 1 ☐ 2 ☐ 3	
Folic acid (separate from prenatal vitamin)			☐ 1 ☐ 2 ☐ 3	

BIRTH

Child's birth weight: ______________________________ Child's length at birth: _________________________________

Number of weeks pregnant when the child was born: ____

Method of delivery (vaginal, cesarean): ____

Length of hospitalization for mother: ___________________________________ Child: ___________________________

Birth complications:

	Yes	No	Explain
NICU stay			
Use of oxygen			
Decreased heart rate			
Jaundice			
Infection			
Seizures			
Low blood sugar			
Unknown			
Other			

CHILD'S MEDICAL HISTORY

	Yes	No	Explain
Dental problems			
Heart problems			
Lung problems (e.g., asthma)			
Constipation			
Other stomach/bowel issues			
Kidney/urinary problems			
Chronic ear infections			
Easy bruising/bleeding/anemia			
Endocrine problems (e.g., thyroid)			
Skeletal/bone problems (e.g., scoliosis)			
Environmental allergies			
Food allergies			
Skin problems (rash/eczema)			
Seizures (list type)			
Wears glasses/contacts			

	Yes	No	Explain
Wears hearing aides			
Cancer			
Chromosomal/genetic disorders			
Broken limbs			
Obesity			
Head injury/loss of consciousness			
Strabismus/lazy eye			
Retinal detachment			
Additional (please list)			

List all hospitalizations for your child, including overnight stays (medical or psychiatric):

Reason for Hospitalization	Age	Date/Year	Length of Stay

Please list all medications that your child is currently taking (e.g., AD/HD medication, Depression medication, over the counter medication, Melatonin, allergy medication, etc.):

Current Medication	Dosage	Reason for Medication	Age When Started	Improved with Medication
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

Has your child received any of the following services?:

	Yes	No	Date	Agency/Provider
Psychological evaluation				
Parent training				
Developmental therapy				
Occupational therapy/evaluation				
Speech therapy/evaluation				
Physical therapy/evaluation				
Early intervention/0-3				
Parents as teachers				
Behavior therapy/ABA				
Counseling				
Child psychiatry evaluation				
Division of Child and Family Services				
Genetic testing				
Neurological screening				
MRI				
Sleep study				
Other services (please list/describe)				

SLEEP HISTORY (Answer about behavior when he/she is NOT on any sleep medication):

Does your child have difficulty with any of the following	How often?		
	Yes	No	Explain
Sleeping too little			
Awaking more than once per night			
Snoring			
Having nightmares/night terrors			
Seems to choke at night			

ACADEMIC/DAYCARE FUNCTIONING

School Contact Information:

Name of child’s school/Daycare: ______________________________

City and state of school/Daycare: ______________________________

Teacher (if a main teacher): ______________________________

What are the 3 main concerns you have about your child's learning?

1. ____________________
2. ____________________
3. ____________________

What best describes your child's current educational placement?

- ☐ Full time regular education
- ☐ Regular class with resource room
- ☐ Time split between regular and special education classes
- ☐ Full-time specialized class
- ☐ Aide/paraprofessional extra help
- ☐ Specialized school
- ☐ Home schooled
- ☐ Not yet in school
- ☐ Daycare

CURRENT SOCIAL/EMOTIONAL FUNCTIONING CURRENT CONCERNS

Please mark any of the following concerns that you have about your child:

	Yes	No	Explain
Appears sad much of the time			
Is often irritable/loses temper			
Self-harm (e.g., cutting, head banging, biting)			
Unusual or excessive fears			
Short attention span			
Impulse-control			
Level of defiance			
Has difficulty with changes in routine/ transitions			
Has difficulty getting along with other children his/her own age			
Seems “stuck” on one topic or activity (e.g., trains, dinosaurs, watching the same movie repeatedly)			
Has difficulty reading other's nonverbal cues, such as gestures and body language			
Difficulty making eye-contact			
Has flat/inappropriate facial expressions			
Difficulty with understanding boundaries (e.g., standing too close to others, etc.)			

INTERESTS/STRENGTHS

What are the 3 best things about your child?

1. ____________________
2. ____________________
3. ____________________

What does your child enjoy doing during his/her free time (e.g., toys, sports, reading, Girl/Cub Scouts, karate, other extra-curriculars, etc.)?: ____

____

____

____

____

How many hours per day does your child spend on screens (e.g., phone, television, tablet, computer, videog-ames, etc.)?:

Weekend: ______ Weekdays: ______

ADDITIONAL INFORMATION

Please use the space below to describe any additional concerns (attach additional sheets if needed):

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Completed By:____

Date Completed: ____

Please email your completed forms to **pediatrictherapyreception@quincymedgroup.com.**

The forms may also be mailed or dropped off at the following address or can be provided at the child's appointment:

Pediatric Therapy
Quincy Medical Group
1101 Maine Street
Quincy, Illinois 62301