



Date Sent: \_\_\_\_\_

Date Return by: \_\_\_\_\_

**Pediatric Therapy  
Speech & Occupational Therapy History Form  
Ages 13+**

For assistance in completing this packet, please call (217) 222-6550, ext. 3255.

Please send completed form to [peditrictherapyreception@quincymedgroup.com](mailto:peditrictherapyreception@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		
Rode a bike without training wheels		
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			
Brushing teeth			
Bathing/showering			
Feed him/herself			
Drinking from an open cup			
Use silverware			
Tying shoes			

Does your child have difficulty with any of the following:

	Yes	No	Explain
Frequent falling			
Catching him/herself while falling			
Confusion with left/right			
Blanking out/hard to get his/her attention			
Numbness/tingling			
Tremors			
Writing his/her name			
Handwriting			
Holding his/her pencil correctly			
Using tools (e.g., pencils, scissors, combs, screwdrivers)			
Has a dominant hand			

	Yes	No	Explain
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)			
Poor posture			
Walking/running			
Jumping			
Skipping or hopping on one foot			
Knowing how to move body (e.g., how to step over something)			
Fatigues easily during active play (e.g., sports, gym class, playground, etc.)			
Overall coordination (explain)			
Displays motor tics			
Displays vocal tics (e.g., noises)			
Stuttering			
Repetitive motor mannerisms (e.g., hand flapping, finger twisting, etc.)			

**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			

**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			



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 occurred 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			

Life Event	Yes	No	Date/Explain
Involvement with DCFS (for child/parent/siblings)			
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			

	Yes	No	Relationship to Child
Other Birth Defects (e.g., cleft lip, club foot, etc.)			
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 pregnancy, 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			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Alcohol			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Street drugs			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Prescription drugs			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Psychiatric medication (e.g., antidepressants/antianxiety, etc.)			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Prenatal vitamin			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Folic acid (separate from prenatal vitamin)			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 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			
Wears hearing aides			

	Yes	No	Explain
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
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> 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: \_\_\_\_\_

City and state of school: \_\_\_\_\_

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

**SCHOOL HISTORY**

School Year	Name of School Attended	Type of Class		Any Special Services (PT, OT, ST, reading help, IEP, etc.)			Additional concerns that year
		General	Special Education	Yes	No	Type	
Preschool							
Kindergarten							
1st							
2nd							
3rd							
4th							
5th							
6th							
7th							
8th							
9th							
10th							
11th							
12th							

**Has your child ever:**

	Yes	No	Explain
Repeated a grade			
Had an IEP			
Had a 504 plan			
Been suspended/expelled from school			
Had difficulty with truancy/missing school			
Had a recent decline in grades			
Had difficulty with making friends/bullying			

**Do you have concerns with the following academic areas?:**

	Yes	No	Explain any concerns
Reading words			
Reading comprehension			
Reading too slow			
Loses place when reading/leaves out small words when reading			
Reversing letters/numbers			
Getting ideas onto paper			
Organizing his/her story writing			
Spelling			
Grammar/punctuation			
Math facts			
Solving math word problems			
Quickly solving math problems			
Vocabulary skills			

**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			
Has lost interest in activities he/she previously enjoyed			
Is often irritable/loses temper			
Has suicidal thoughts			
Self-harm (e.g., cutting, head banging, biting)			
Reports hearing/seeing things that are not there			
Uses drugs/alcohol			
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			
Has trouble understanding sarcasm/other sayings (e.g., "it's raining cats and dogs.")			
Seems "stuck" on one topic or activity (e.g., trains, Minecraft, watching the same movie repeatedly)			
Has difficulty reading other's nonverbal cues, such as gestures and body language			
Difficulty understanding the feelings of others			
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, videogames, etc.)?:

Weekend: \_\_\_\_\_ Weekdays: \_\_\_\_\_

**ADDITIONAL INFORMATION**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Completed By: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Please email your completed forms to [pediatrictherapyreception@quincymedgroup.com](mailto: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**