



Date Sent: _____

Date Return by: _____

**Pediatric Therapy
Speech, Occupational, & Physical Therapy History Form
Ages 4-12**

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

Please send completed form to 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			
Tie 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			
Knowing how to move body (e.g., how to step over something)			
Writing his/her name			
Handwriting			
Holding his/her pencil correctly			
Using tools (e.g., pencils, scissors, combs, screwdrivers)			

	Yes	No	Explain
Has a dominant hand			
Turning doorknobs/handles/opening and closing items			
Picking up and grasping small objects			
Throwing/catching a ball			
Riding a bike without training wheels			
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			
Skipping			
Walking on toes			
Walking/running			
Overall coordination (explain)			
Displays motor tics			
Displays vocal tics (e.g., noises)			
Stuttering			
Repetitive motor mannerisms (e.g., hand flapping, finger twisting, etc.)			
Comprehending written directions			
Comprehending spoken directions			
Using grammar appropriately			
Being understood by others when speaking			
Rhyming skills or phonics skills			
Coming up with correct words 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	<input type="checkbox"/> Wearing new or stiff clothing <input type="checkbox"/> Always has to have tags cut out <input type="checkbox"/> Refuses to wear constrictive clothing (turtlenecks, jeans, hats, belts, etc.) <input type="checkbox"/> Distressed by seams in socks
Sensitive to touching	<input type="checkbox"/> Avoids touching certain textures of materials (e.g., blankets, rugs, stuffed animals, vibrating/slippy/slimy toys) <input type="checkbox"/> Bothered by certain bed sheets (e.g., has to have specific texture of sheets) <input type="checkbox"/> 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.) <input type="checkbox"/> May refuse to walk barefoot on grass or sand <input type="checkbox"/> Resists being held or cuddled
Difficulty tolerating grooming tasks	<input type="checkbox"/> Distressed when having face washed or getting water on face <input type="checkbox"/> Distressed when having hair cut <input type="checkbox"/> Distressed when having toenails/fingernails cut <input type="checkbox"/> Distressed when having hair washed (e.g., tipping head backwards) <input type="checkbox"/> Not usually aware when hands or face are dirty or feels his/her nose running
Craves touch	<input type="checkbox"/> Constantly touching objects and people <input type="checkbox"/> Fidgets frequently <input type="checkbox"/> Thoroughly enjoys and seeks out messy play (e.g., sand, mud, glue, etc.) <input type="checkbox"/> Shows no distress with shots
Avoids movements	<input type="checkbox"/> Avoids playground equipment <input type="checkbox"/> Avoids rotating movements (e.g., merry-go-rounds or tire swings) <input type="checkbox"/> Prefers sedentary activities
Afraid of heights	<input type="checkbox"/> Afraid of falling <input type="checkbox"/> Avoids/dislikes elevators and escalators; may prefer sitting while he/she is on them <input type="checkbox"/> Fearful of going up or down stairs or walking on uneven surfaces (e.g., curbs)
Seeks movement	<input type="checkbox"/> Child seems to move more than other children his/her age <input type="checkbox"/> Craves fast, spinning, and/or intense movement experiences <input type="checkbox"/> Always jumping on furniture, trampolines, spinning in a swivel chair, or getting into upside down positions <input type="checkbox"/> Loves to swing as high as possible and for long periods of time <input type="checkbox"/> Is a “thrill-seeker” and is dangerous at times <input type="checkbox"/> Has difficulty sitting at the table for meals <input type="checkbox"/> Has difficulty sitting to complete activities <input type="checkbox"/> Seeks out jumping, bumping, and crashing activities <input type="checkbox"/> Usually runs, jumps, and hops when he/she should be walking
Seeks out rough and tough play activities	<input type="checkbox"/> Constantly jumping and crashing <input type="checkbox"/> Frequently falls on floor intentionally <input type="checkbox"/> Could jump on a trampoline for hours <input type="checkbox"/> Frequently jumps off furniture or from high places <input type="checkbox"/> When in a store or at home he/she may seem like a “bull in a china shop”

Seeks out deep pressure	<input type="checkbox"/> Uses a weighted blanket to sleep <input type="checkbox"/> Excessively asks for bear hugs <input type="checkbox"/> Prefers clothes (and belts, hoods, shoelaces) to be as tight as possible
Uses too much force	<input type="checkbox"/> Too rough when playing with peers <input type="checkbox"/> Accidentally too rough with animals <input type="checkbox"/> Often breaks objects or toys <input type="checkbox"/> Stomps when walking <input type="checkbox"/> Accidentally slams doors <input type="checkbox"/> Presses buttons too hard <input type="checkbox"/> Accidentally slams objects down <input type="checkbox"/> Pushes too hard on pencil or writes too light to see
Sensitive to sounds	<input type="checkbox"/> Covers ears with loud noises <input type="checkbox"/> 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) <input type="checkbox"/> Fearful of the sound of a flushing toilet (especially in public bathrooms), vacuum, hairdryer, squeaky shoes, or a dog barking <input type="checkbox"/> May refuse to go to movie theaters, parades, skating rinks, parties, musical concerts, etc. because they are too loud <input type="checkbox"/> Sensitive to sounds such as pencil tapping, pen clicking, talking, singing, whistling, etc.
Needs auditory repetition	<input type="checkbox"/> Often does not respond to verbal cues or to name being called <input type="checkbox"/> Needs directions repeated often, or will say, "What?" frequently <input type="checkbox"/> Talks to self while completing tasks <input type="checkbox"/> Makes noises during inappropriate times
Oral sensitivity	<input type="checkbox"/> Difficulty tolerating tooth brushing <input type="checkbox"/> Dislikes or complains about toothpaste and mouthwash <input type="checkbox"/> May lick, taste, or chew on inedible objects (e.g., hair, shirt, fingers, shirt sleeves, pens, etc.) <input type="checkbox"/> Drools <input type="checkbox"/> Loves vibrating toothbrushes
Olfactory sensitivity	<input type="checkbox"/> Overly sensitive to smells that do not usually bother or get noticed by others <input type="checkbox"/> Refuses to eat certain foods because of their smell <input type="checkbox"/> Bothered/irritated by smells (e.g., perfume, cologne, bathroom odors, personal hygiene smells, cleaning products, air fresheners, household, cooking, etc.) <input type="checkbox"/> May drink or eat things that are poisonous because he/she does not notice the noxious smell <input type="checkbox"/> Does not notice odors that others usually complain about <input type="checkbox"/> May sniff toys, objects, people, or places
Visual sensitivities	<input type="checkbox"/> Sensitive to bright lights; will squint, cover eyes, cry and/or get headaches from the light <input type="checkbox"/> Has difficulty keeping eyes focused on activity that he/she is working on for an appropriate amount of time <input type="checkbox"/> 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			

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.): _____

Current Living Situation

People living in the same household as the child:

Name	Age	Relationship to Child	Occupation

Child's brothers or sisters living OUTSIDE of the home:

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			

	Yes	No	Date/Explain
Caregiver psychiatric hospitalization			
Caregiver/sibling medical hospitalization			
Significant caregiver travel			
Homelessness			
Domestic violence			
Living in a shelter			
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			

	Yes	No	Relationship to Child
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.)			
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

Has your child received any of the following services?:

	Yes	No	Date	Agency/Provider
Psychological evaluation				
Parent training				
Developmental therapy				
Occupational therapy/evaluation				

	Yes	No	Date	Agency/Provider
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			

	Yes	No	Explain any concerns
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.

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**