



Children's Therapy and Rehab Specialists
Child History Form

Today's Date: _____ Completed by: _____

Child's Name: _____ Date of Birth: _____ Age: _____
Parents/Guardians full names: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell phone: (____) _____

In case of emergency, if you can not be reached at home, we can contact:

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell phone: (____) _____

Primary Physician: _____ Phone: (____) _____
Address: _____

Please list on back or separate sheet of paper, any specialists that your child has seen (neurologist, orthopedist, optometrist, etc.): _____

Insurance Information:

Company: _____ Insured: _____ DOB _____
ID# _____ Grp#: _____
Is there a second insurance? If so what company? _____
ID#: _____ Grp#: _____
Insured Name and date of birth: _____

Medical Diagnosis: _____

Reason for Referral: _____

Birth Information:

Complications/Health problems with mother during pregnancy: (if yes please explain)

Gestational age (length of pregnancy): _____ birth weight: _____ Apgar scores: _____
Type of delivery: vaginal _____ C-section _____ breech _____ forceps _____ other _____
Complications following delivery: Jaundice _____ Breathing _____ Heart problems _____ Seizures _____
Poor Suck _____ Other: _____
Infants length of hospital stay: _____ NICU length of stay: _____

Child's Health and Medical History:

Pneumonia: _____ Reflux: _____ Allergies: _____ Chicken Pox: _____ Seizures: _____ (Please describe and indicate frequency of seizures): _____

Ear infections: _____ Frequency/last ear infection: _____

General Health: _____

List any food allergies: _____

Family medical history significant to your child? _____

What family member? Mom ___ Dad ___ Grandma ___ Grandpa ___ Aunt ___ Uncle ___ other: _____

Medical Procedures/Medications: (Please list dates if applicable)

Ear Tubes: _____ Still in place? _____ Trach: _____ G-tube: _____ Shunt: _____

Tonsillectomy: _____ Heart Surgery? _____ Type: _____

Other _____

Please list any current medications and reason for use: _____

Developmental Milestones:

Please list the ages that your child reached the following developmental milestones:

Lift head when on stomach _____ Roll over _____ Sit without support _____ Crawl _____

Stand alone _____ Walk _____ Dress/undress self _____ Button/zip clothes _____

Started solid foods _____ Held cup _____ Used spoon _____ Hand preference _L_ R_

Dry during day _____ Dry at night _____ Gain bowel control _____

Does your child have any bowel or bladder difficulties? Please describe _____

Speech:

Please list the ages that your child achieved the following:

Babbling (baba, dada, etc.): _____ First words: _____ Combined Words: _____

Does your child imitate sounds and/or words: _____

Describe your child's overall speech currently: _____

Does your child respond to speech (their name, directions, etc.): _____

Do you frequently have to repeat directions: _____

What are your greatest concerns about your child's speech and language: _____

Gross Motor:

Describe position(s) your child spends time in at home (held, on stomach/back, sitting, etc.): _____

Describe how your child moves around the house: _____

Describe any atypical motor movements: _____

Does your child fall or lose balance easily: _____

What are your greatest concerns about your child's gross motor skills: _____

Fine Motor & Sensory Processing:

Does your child have any difficulty using their hands to play or manipulate objects: _____

Describe activities your child enjoys most at home: _____

Describe your child's overall attention span: _____

Describe your child's interaction with toys/objects: _____

Describe your child's independence with "self-care" tasks (dressing, feeding, etc.): _____

Describe your child reactions to "sensory input" (touch, noise, visual, movement, etc.): _____

What are your greatest concerns about your child's fine motor and sensory processing skills: _____

Previous Therapy/Intervention:

Please list any services received in the past _____

Social/Behavioral:

Please describe the things you love most about your child: _____

Please describe what concerns you most about your child: _____

How does your child calm him/herself: _____

How does your child interact in social/group settings: _____

Describe your child's communication with peers: _____

Is a second language spoken at home: _____

How many siblings in the family, please list if brother or sister and ages: _____

General:

Are there any foods that your child is not allowed to have? Please list: _____

May the therapist use food as a therapy tool if appropriate: _____

Is your child allowed to have lollipops or candy? _____

Please describe your discipline approach in the home: (i.e. redirection, positive reinforcement, time-out, etc) _____

Please describe what best motivates and/or reinforces your child's behavioral: (i.e. specific activities, toys, stickers, rewards, etc): _____

Please indicate what methods the therapist may use to manage your child's behavior during therapy sessions:

- a. verbal redirection to a task
- b. hand-over-hand guidance through activity
- c. reinforcement with stickers
- d. reinforcement with candy (lollipops)
- e. "time-out"

School District your child attends: _____

Teacher Name and School Phone Number: _____

Any therapy at school? If so what: speech: _____ occupational: _____ physical therapy: _____

Name of therapists and phone number: _____

Explain what you expect from this evaluation. Identify main concerns and what other information or references would help you most:

HOW DID YOU HEAR ABOUT US? Doctor (name) _____ or mark X on any of the following that applies:

Internet ___ **Phone book** ___ **Friend** ___ **Drive by** ___ **Ins. Co.** ___ **Other** ___

Explain other: _____

Thank you for taking the time to complete this history form. The information received in this form is confidential information and intended for our use only unless otherwise authorized by you, the parents or legal guardians. The information will help provide the most efficient and accurate evaluation possible. If there are any questions pertaining to this history form, or more specific concerns about your child, please do not hesitate to discuss this with your child's therapist at Children's Therapy and Rehab Specialists. Our goal is to provide you with the most concise and comprehensive evaluation and treatment plan possible. Again, thank you for your time and effort in completing this form.

CHILDREN'S THERAPY AND REHAB SPECIALISTS

Parent/Guardian Signature

Date