



### CHILD HISTORY

CHILD'S NAME \_\_\_\_\_

CHILD'S DATE OF BIRTH \_\_\_\_\_

DATE QUESTIONNAIRE WAS COMPLETED \_\_\_\_\_

PARENT'S/GUARDIANS PHONE \_\_\_\_\_

NAME OF PERSON WHO FILLED OUT QUESTIONNAIRE \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

MOTHER'S OCCUPATION \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_

FATHER'S OCCUPATION \_\_\_\_\_

### ABOUT YOUR CHILD

- Does your child have any medical alerts (e.g. asthma, seizures, heart condition, or shunt), precautions, or activity restrictions?  Yes  No If yes, please indicate:  
\_\_\_\_\_
- Does your child have allergies, intolerances, or diet restrictions?  Yes  No If yes, please indicate:  
\_\_\_\_\_
- Does your child take any medications?  Yes  No If yes, please indicate:  
\_\_\_\_\_
- Does your child use any type of adaptive equipment (e.g. braces, crutches, walker, wheelchair, splints)  Yes  No If yes, please indicate:  
\_\_\_\_\_
- What are your main concerns regarding your child, or goals you would like to addressed for your child?  
\_\_\_\_\_
- What do you see as your child's strengths?  
\_\_\_\_\_
- Are there any special instructions or suggestions for us when working with your child?  Yes  No If yes, please indicate:  
\_\_\_\_\_

### REFERRAL INFORMATION

- Why was your child referred for services? \_\_\_\_\_
- Who referred your child to us for services? \_\_\_\_\_

### CURRENT PHYSICIANS

Name and Specialty	Phone	City and State
_____	_____	_____
_____	_____	_____
_____	_____	_____

## MEDICAL INFORMATION

Medical Diagnosis

Date of Diagnosis

Diagnosed by Whom

---

---

---

---

---

---

---

---

---

---

---

---

## PRENATAL AND BIRTH HISTORY

1. Birth Weight \_\_\_\_\_ Birth Height \_\_\_\_\_ Due Date \_\_\_\_\_ Delivery Date \_\_\_\_\_
2. Place of Birth (Hospital, City, State) \_\_\_\_\_
3. Type of Delivery  Vaginal  Breech  Cesarean
4. Were there any complications during pregnancy or delivery?  Yes  No If yes, please indicate: \_\_\_\_\_
5. How was your child's health at delivery and during the hospital stay? \_\_\_\_\_

## HISTORY OF HOSPITALIZATIONS AND SURGERIES

Reason

Hospital/Facility

Physician

Dates

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

## HEARING STATUS

1. Does your child have a history of ear infections?  Yes  No
2. Does your child have PE tubes?  Yes  No
3. Do you have any concerns regarding your child's hearing?  Yes  No If yes, please indicate: \_\_\_\_\_
4. Has your child's hearing ever been tested?  Yes  No
  - a. If yes, when was it tested? \_\_\_\_\_
  - b. Who did the testing? \_\_\_\_\_
  - c. What were the findings? \_\_\_\_\_
5. Does your child use a hearing aid or any other assistive device?  Yes  No If yes, please indicate: \_\_\_\_\_

## VISION STATUS

1. Do you have any concerns regarding your child's vision?  Yes  No If yes, please indicate: \_\_\_\_\_
2. Has your child's vision ever been tested?  Yes  No
  - a. If yes, when was it tested? \_\_\_\_\_
  - b. Who did the testing? \_\_\_\_\_
  - c. What were the findings? \_\_\_\_\_
3. Does your child wear glasses/contact lenses?  Yes  No If yes, please indicate: \_\_\_\_\_

## PREVIOUS THERAPY/SERVICE HISTORY

Therapy/Service	Name of Provider/Facility	Location	Dates	Frequency
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## COMMUNICATION

1. Does your child enjoy social games (e.g., peek-a-boo)?  Yes  No  Not Yet Old Enough
2. Did your child babble as an infant?  Yes  No  Not Yet Old Enough
3. Did your child's babbling grow or change in regard to frequency and variety of sounds?  
 Yes  No  Not Yet Old Enough
4. Please check all boxes to indicate the ways in which your child **communicates**:
  - Crying
  - Shifting eye-gaze
  - Making facial expressions
  - Vocalizing (making sounds that are not words)
  - Babbling (making a variety of consonant/vowel sounds that are not words)
  - Gesturing
  - Using sign language
  - Leading you to item
  - Pointing
  - Approximating words (making sounds that sound like words)
  - Saying single words
  - Saying 2-3 word utterances
  - Talking in sentences
  - Using detailed phrases
  - Using assistive technology/communication device (type used: \_\_\_\_\_)
5. Has your child said his/her first word?  Yes  No  Not Yet Old Enough
6. Does your child say more than 1 word?  Yes  No  Not Yet Old Enough
  - a. If yes, how many words does your child currently say? \_\_\_\_\_
  - b. If under 30, please list \_\_\_\_\_
7. Does your child readily imitate new words?  Yes  No  Not Yet Old Enough
8. Does your child use words consistently and expand in his/her vocabulary?  
 Yes  No  Not Yet Old Enough
9. How does your child let you know when he/she is frustrated?  
\_\_\_\_\_
10. Does your child speak in sentences/phrases?  Yes  No  Not Yet Old Enough If yes, please provide an example:  
\_\_\_\_\_
11. What is the estimated percentage that unfamiliar people understand your child? \_\_\_\_\_%
12. Is your child aware of his/her communication difficulty?  Yes  No  Not Applicable

13. Please check all boxes to indicate the things that your child **understands**:

- How to read facial expressions
- What some gestures mean
- What some sign language means
- What some pictures mean
- Single words
- Simple phrases
- One part commands/directions
- Two to three part commands/directions
- Conversation

14. Do you have concerns regarding what your child understands?  Yes  No If yes, please indicate:

---

## FEEDING

1. How is your child fed? (Please check all that apply)

- Breast fed
- Bottle fed
- Orally fed
  - Pureed foods
  - Stage 1 baby foods
  - Stage 2 baby foods
  - Toddler foods
  - Toddler foods
  - Eats from spoon held by adult
  - Uses spoon independently
  - Eats from fork held by adult
  - Uses fork independently
  - Cuts food with knife and fork
  - Drinks from sippy cup held by adult
  - Drinks from sippy cup held independently
  - Drinks from regular cup held by adult
  - Drinks from regular cup held independently
- Naso Gastric Tube
- Gastric Tube

2. Does your child have any difficulties with feeding?  Yes  No If yes, please indicate (Please check all that apply):

- Is picky with textures, temperatures, colors, tastes (Preferences: \_\_\_\_\_)
- Has trouble using tongue or lips to get food
- Chews with open mouth
- Gags (When: \_\_\_\_\_)
- Chokes (When: \_\_\_\_\_)

- Is a very messy eater
- Avoids getting messy
- Other (Please indicate): \_\_\_\_\_

- 
3. What types of food does your child like? \_\_\_\_\_
  4. What types of food does your child dislike? \_\_\_\_\_
  5. Does your child have a history of "spitting up" frequently?  Yes  No
  6. Does your child have a diagnosis of gastroesophageal reflux?  Yes  No

## SELF HELP

1. Does your child undress him/herself?
  - Yes, completely (including unfastening and untying)
  - No, still needs help (Please Indicate: \_\_\_\_\_)
2. Does your child dress him/herself?
  - Yes, completely (including fastening and tying)
  - No, still needs help (Please Indicate: \_\_\_\_\_)
3. Does your child have strong clothing preferences?  Yes  No If yes, please give examples: \_\_\_\_\_

---

4. Does your child tolerate tooth/gum brushing?  Yes  No
5. Does your child brush his/her teeth independently?
  - Yes, completely (including getting the tooth paste on the tooth brush)
  - No, still needs help (Please Indicate: \_\_\_\_\_)
6. What do you or your child use to brush his/her teeth/gums?
  - Wash cloth
  - Infadent
  - Regular tooth brush
  - Electric tooth brush
  - Water pic
7. Does your child fall asleep easily?  Yes  No
8. Once asleep, does your child sleep through the night?  Yes  No
  - a. If no, how many times does he/she wake in the night? \_\_\_\_\_
  - b. What does it take to get him/her back to sleep \_\_\_\_\_
9. How does your child sleep (Please check all that apply)?
  - Alone
  - With sibling
  - With parents
  - In crib
  - In toddler bed
  - In regular bed
  - Other (Please describe: \_\_\_\_\_)
10. Please describe your child's bed time routine: \_\_\_\_\_

## PLAY

1. Does your child initiate playing with you?  Yes  No others?  Yes  No If yes, describe how:  

---
2. Please complete: My child prefers to interact with  children of the same age  younger children  
 older children  adults  people of all ages
3. Does your child become easily frustrated when playing?  Yes  No If yes, please indicate:  

---
4. Is your child rigid in play (e.g. can only swing on the same swing, certain toy figures can only go in certain places, or the cars need to be lined up exactly so)?  Yes  No If yes, please indicate:  

---
5. Does your child have a variety of play skills?  Yes  No
6. What are your child's favorite play activities or toys?  

---
7. How does your child respond to the following types of sensory activities (Please check all that apply)?  
Tactile (e.g. finger paint, sand, glue, or dirt)  
 Avoids/Hesitates  Seeks out  Participates typically for age  
Movement (e.g. rocking, riding, swinging, climbing, or sliding)  
 Avoids/Hesitates  Seeks out  Participates typically for age  
Muscle (e.g. pushing or pulling)  
 Avoids/Hesitates  Seeks out  Participates typically for age  
Sounds (e.g. musical, loud parties, or banging)  
 Avoids/Fears  Seeks out  Participates typically for age  
Vision (e.g. bright lights or spinning objects)  
 Avoids/ Hesitates  Seeks out  Participates typically for age
8. Please indicate any special notes about sensory observations here:  

---

  

---

  

---
9. Does your child have any difficulty with focus or attention?  Yes  No If yes, please indicate:  

---

## DEVELOPOMENTAL MILESTONES

1. Please indicate if/when your child met the following motor milestones:  
Rolled  Age: \_\_\_\_\_  Has not yet done or skipped  Not Old Enough  
Crept hands and Knees  Age: \_\_\_\_\_  Has not yet done or skipped  Not Old Enough  
Walked without Support  Age: \_\_\_\_\_  Has not yet done or skipped  Not Old Enough  
Potty Trained  Age: \_\_\_\_\_  Has not yet done or skipped  Not Old Enough

## OTHER

---

---

---