Name of Child:_____

Child's Date of Birth: _____

Person Completing the Form: _____

Pregnancy Without Complications With Complications	Length of Pregnancy Prenatal Care was Received Yes No

Pregnancy Complications

___Eclampsia ___Multiple Births ___Positive for Cytomegalovirus (CMV)

___Gestational Diabetes ___Polyhydramnios ___Positive for Herpes

___Positive for HIV ___Positive for Strep B ____Pre-eclampsia

___Premature Labor ___Substance Exposure ___Toxemia

___Other: Please Specify:

Birth Information

___Mother's Age at time of birth: _____

Birth Hospital:_____

Needed to be Transferred to another Hospital: Yes No

Transfer Hospital:_____

Birth Weight _____

Birth Height _____

Apgar Score:

_____ 1 minute _____5 minutes _____10 minutes

For this Pregnancy

Were there multiple children born from this pregnancy? ____Yes ____No

Number of Live Births _____

Number of Still Births_____

Additional Information Regarding Birth:

Please Add Any Other Comments Regarding Pregnancy or Birth History:	Delivery Proceeded ___Without Complications ___With Complications

Delivery Complications:

___Abrupto Placenta

___Breech Presentation

___Low Birth Weight

___Negative Vacuum

___Non-progressive Unproductive Labor

___Occipital Posterior Position (Face Up)

___Transverse Presentation

___Prolasped Cord

___Use of Forceps

___Uterine Rupture

___Umbilical cord around the neck

Delivery Complications Continued:

___Placenta Previa

___Premature Rupture of Membranes

___Other Please Specify:

FOLLOWING BIRTH

Complications Following Birth: ___Yes ___No

___Anemia of Prematurity ___Bronchopulmonary Dysplasia “BPD” ___Cleft Lip

___Cleft Palate ___Club Foot ___Cytomegalovirus

___ECMO ___Failure to Thrive ___Hyperbilirubinemia

___Intrauterine Growth Retardation “IUGR” ___IVH Grade I

___IVH Grade II ___IVH Grade III ___IVH Grade IV

___Jaundice treated with photo-light therapy &/or bilirubin blanket ___Meconium Aspiration

___Meconium Aspiration ___Necrotizing Enterocolitis “NEC” ___Neonatal Hypoxia

___Oxygen Dependency ___PDA ___Respiratory Distress Syndrome

___Respiratory Strider ___Respiratory Syncytial Virus “RSV”

___Retinopathy Of Prematurity “ROP” ___Thrombocytopenia (Low Platelet Count)

___Ventilator Dependency ___VP Shunt

OTHER COMPLICATIONS:

DIAGNOSED/SUSPECTED SYNDROMES:

CURRENT MEDICATIONS:

ALLERGIES:	
CURRENT VITAMINS, HERBS, MINERALS, HOMEOPATHETICS:	
HEARING TEST: NORMAL Hearing Test Results ___Yes ___No VISION TEST: Normal Vision Test Results ___Yes ___No	Date Hearing Tested:_____ Concerns: _____
Date Vision Tested: _____ Concerns: _____	Name of Vision Specialist:

Physician	Specialty	Reason	Date of Last Date

Surgery/Procedure	Date

Diagnostic Test	Date	Results

Does the Child Have:

___ Allergies Please Specify: _____

___Anoxia Brain Injury	___Asthma/Respiratory Breathing Problems	
___Autism	___Baclofen Pump	___Cerebral Palsy
___Cerebral Vascular Accident "CVA"	___Chronic Ear Infections	___Colic
___Constipation	___Diarrhea	___Down Syndrome
___Hip Subluxation	___Hydrocele	___Laryngomalacia

___Muscular Dystrophy	___Osteoporosis	___Reflux
___Plagiocephaly	___Cranial Helmet	
___Periventricular Leukomalacia	___Seizures	___Scoliosis
___Sleep Disorder	___Sleep Problems	___Shunts
___Torticollis	___Traumatic Brain Injury	___Tube Feeding
___Tubes in Ears	___Vagal Nerve Stimulator	
Medical Conditions:		

Orthopedic Conditions:

Feeding History: ____Tube Feeding ____Breast-Feeding ____Baby Food Stage ____Table Foods ____Eats what family eats Eats Vegetables Eats Fruits	Eats Meats Becomes Upset with foods on face or hands Drinks from ___Sippy Cup ___Straw ___Open Cup

When Did the Child Begin: Began at Age:

Bring Both Hands to Mouth	
Rolling	
Sitting	
Crawl on hands and knees	
Walk	
Jump	
Ride a Bike	
Toilet Trained	

Holding Own Bottle	
Fork Feeding	
Spoon Feeding	
Tying Shoes	
Buttoning	

Child is ____Right Handed ___Left Handed ____No Hand Preference

Concerns about Handwriting? ____Yes ____No

Child Has IEP or 504 Plan ___Yes ___No School Concerns and Supports:

Child's Favorite Toys/Activities

Description of Child:

___Active	___Affectionate	___Aggressive	___Calm
___Cautious	___Curious	___Demanding	____Difficult to Calm
___Distractible	___Fearful	___Fearless	____Fussy
___Insecure	___Motivated	___Passive	___Persistent
___Playful	___Shy	___Stubborn	___Withdrawn

OTHER:

SENSORY PROCESSING/REGULATION

___Avoids Getting Messy	___Seeks Touch
___Seeks Movement	___Seeks Crashing Behaviors
___Stumbles/Falls Frequently	___Appears Clumsy/Less Coordinated
___Flaps Hands	___Difficulty having teeth brushed
___Bangs/Hit Own Head	___Walks with Heavy Feet
___Fatigues Quickly	___Has Self-Abusive Behaviors
___Resists certain Environments	___Spins things or self

___Sensitive to Lights

___Sensitive to Sounds

___Sleeps a Lot

___ Resists Touch

___Walks on Toes

___Lines up toys or objects

___Seeks out Visually Stimulating Objects

___Seeks out Stimulating Sounds

___Resists certain Movements (bouncing, swinging)

___Takes More time with Movements

___Does Not Tolerate Certain Textures of Fabrics

___Does Not Tolerate Certain Textures of Foods

___Uses a lot of Pressure when Touching Someone, Pets, or Holding Objects

___Has difficulty transitioning from one activity to another

___Has difficulty Falling Asleep

___Has difficulty Staying Asleep

___Appears Lethargic or Sleepy all the time

___Has Poor Body Awareness and Bumps into Things or Unaware of edges of elevated surfaces

___Seeks Support for Posture (leans on furniture, walls, or people, wants to be held)

___Demonstrates Rigid or Stiff Movement Patterns

___Hyper focused on people or objects

OTHER:

SOCIAL EMOTIONAL

___Easily Distracted	___Calms Self Easily	___Gets Angry/Frustrated Easily
___Aggressive Towards Others	___Prone to Outbursts	___Doesn't Allows Others to Play
___Has Difficulty Making Friends	___Plays with Peers	___Only Plays with Adults
___Prefers to Play Alone	___Difficulty with Separation	___Poor Eye Contact

OTHER:

Describe any Feeding Concerns:	Food Preferences:	Food Dislikes:

When did the child begin:
Using a Bottle_____

Stop Using a Bottle _____

Holding their own Bottle _____

Using a Pacifier_____

Stop Using a Pacifier _____

Eating Baby Food _____

Eating Table Food _____

Self- Feeding with their hands _____

Using Utensils to Eat _____

Drink from an Open Cup _____

Drink from a Sippy Cup _____

Drink from a Straw _____

Breastfeeding

_____ Currently Number of Times a Day _____

_____ Weaned At What Age _____

_____ Never

Areas of Difficulty

_____ Chewing _____ Food Textures

_____ Drooling _____ Food "Jags" Likes a food for a period of time and then will not eat that food

_____ Swallowing

Current Feeding Adaptions

_____ Thickened Liquids

____ Adapted Utensils

_____ Adapted Seating Device

_____ Tube Feeding

COMMUNICATION

Primary Communication is _____ Verbal _____ Non-Verbal

Does the Child:

Have speech that most people understand? _____ YES _____ NO

Respond correctly to yes/no questions? _____ YES _____NO

Follow simple directions? _____ YES _____NO

Respond when name is called? _____ YES _____NO

Stutter? _____ YES _____NO

Recognize People, Objects, and Places? _____ YES _____NO

When did the child begin to :

Babble _____

Say First Words _____

Use Short Sentences _____

NON-VERBAL COMMUNICATION

Select the Primary Non-Verbal Communication Modes Used:

_____ Facial Expressions _____ Gestures _____ Pointing

_____ Body Language _____ Sign Language _____ Eye Gaze

If an augmentive communication device is used:

When did this start and what type of device?

HOME ENVIRONMENT

Child Lives with

_____ Birth Mother _____ Adoptive Mother

_____ Birth Father _____ Adoptive Father

_____ Step-Mother _____ Grandmother

_____ Step-Father _____ Grandfather

_____ Siblings

List number of Siblings and Ages:

Language Spoken in the Home:

EQUIPMENT Currently or in the Past

_____ Eyeglasses	_____ Hearing Aids	_____ Cochlear Implants
_____ Foot/Leg Braces	_____ Hand Splints	_____ Trunk Braces
_____ Cranium Helmet	_____ Walker	_____ Manual Wheelchair
_____ Power Wheelchair	_____ Abdominal Binder	_____ COMPRESSION Garment

SCHOOL:
Grade:

Does your child have an IEP? _____ Yes _____ No

Does your child have an IFSP? _____ Yes _____ No

What Services does your child receive in School or in Early Intervention Program?
_____ Occupational Therapy _____ Physical Therapy _____ Speech Therapy

_____ Developmental Therapy _____ Social Work _____ Assistive Technology

What Private Therapy Services does your child receive?

_____ Occupational Therapy _____ Physical Therapy _____ Speech Therapy

_____ Developmental Therapy _____ Social Work _____ Assistive Technology