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| 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 \_\_\_Transverse Presentation  \_\_\_Breech Presentation \_\_\_Prolasped Cord  \_\_\_Low Birth Weight \_\_\_Use of Forceps  \_\_\_Negative Vacuum \_\_\_Uterine Rupture  \_\_\_Non-progressive Unproductive Labor \_\_\_Umbilical cord around the neck  \_\_\_Occipital Posterior Position (Face Up)  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: | |

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| 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: |
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| Physician | Specialty | Reason | Date of Last Date |
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| Surgery/Procedure | Date |
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| Diagnostic Test | Date | Results |
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| 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: |

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| Orthopedic Conditions: |

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| 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:

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

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| Holding Own Bottle |  |
| Fork Feeding |  |
| Spoon Feeding |  |
| Tying Shoes |  |
| Buttoning |  |
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Child is \_\_\_\_Right Handed \_\_\_Left Handed \_\_\_\_No Hand Preference

Concerns about Handwriting? \_\_\_\_Yes \_\_\_\_No

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| Child Has IEP or 504 Plan \_\_\_Yes \_\_\_No  School Concerns and Supports: |

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| Child’s Favorite Toys/Activities |

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| 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: |

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| 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: |

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| 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: |

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| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Breastfeeding  \_\_\_\_\_ Currently Number of Times a Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_ Weaned At What Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_ Never |

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| 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

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| 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 |

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| 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

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| 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 |
|  |