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| PregnancyWithout ComplicationsWith Complications | Length of PregnancyPrenatal 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 NoTransfer Hospital:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apgar Score:\_\_\_\_\_\_ 1 minute \_\_\_\_\_5 minutes \_\_\_\_\_\_10 minutesFor this Pregnancy Were there multiple children born from this pregnancy? \_\_\_\_Yes \_\_\_\_NoNumber 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 BIRTHComplications 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 \_\_\_NoVISION 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 eatsEats Vegetables Eats Fruits | Eats MeatsBecomes Upset with foods on face or handsDrinks 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 \_\_\_NoSchool 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 \_\_\_WithdrawnOTHER: |

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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 objectsOTHER: |

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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 ContactOTHER: |
| 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-VerbalDoes the Child:Have speech that most people understand? \_\_\_\_\_ YES \_\_\_\_\_ NORespond correctly to yes/no questions? \_\_\_\_\_ YES \_\_\_\_\_NOFollow simple directions? \_\_\_\_\_ YES \_\_\_\_\_NORespond when name is called? \_\_\_\_\_ YES \_\_\_\_\_NOStutter? \_\_\_\_\_ YES \_\_\_\_\_NORecognize 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 COMMUNICATIONSelect 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 \_\_\_\_\_ NoDoes your child have an IFSP? \_\_\_\_\_ Yes \_\_\_\_\_ NoWhat Services does your child receive in School or in Early Intervention Program?\_\_\_\_\_ Occupational Therapy \_\_\_\_\_\_ Physical Therapy \_\_\_\_\_ Speech Therapy\_\_\_\_\_ Developmental Therapy \_\_\_\_\_\_ Social Work \_\_\_\_\_ Assistive TechnologyWhat Private Therapy Services does your child receive?\_\_\_\_\_ Occupational Therapy \_\_\_\_\_\_ Physical Therapy \_\_\_\_\_ Speech Therapy\_\_\_\_\_ Developmental Therapy \_\_\_\_\_\_ Social Work \_\_\_\_\_ Assistive Technology |
|  |