



*When your child needs help, there is hope.*

## Getting to Know Your Child

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Health History:

Were there any complications ... (if yes, please explain)

...during pregnancy	Y/N	
...at birth	Y/N	
...with speech/language development	Y/N	
...with development of fine motor skills	Y/N	
...with development of gross motor skills	Y/N	

Length of pregnancy: \_\_\_\_\_ Length of Labor: \_\_\_\_\_

Birth style: \_\_\_ vaginal \_\_\_ caesarian \_\_\_ breech \_\_\_ twins or more Birth weight: \_\_\_\_\_

Please tell us about any significant past medical history (i.e., hospitalizations, surgery etc.)

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Who is your child's primary care physician or other professional healthcare provider? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Has your child had a hearing test: No \_\_\_ Yes \_\_\_ If yes, when \_\_\_\_\_ Passed? No \_\_\_ Yes \_\_\_

Has your child had an eye exam: No \_\_\_ Yes \_\_\_ If yes, when \_\_\_\_\_ Passed? No \_\_\_ Yes \_\_\_

Is your child currently taking any medication? No \_\_\_ Yes \_\_\_ If yes, please complete

Medication	Reason	Date Began	Side Effects?

**Allergies:**

Please list all allergies your child has:

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**Educational Information:**

Child's School/Day Program: \_\_\_\_\_

May we contact your child's school if needed? Y/N School's phone number: \_\_\_\_\_

Is your child in a special class or receiving any services through the school? (Specify)

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**Previous Therapy:**

Has your child been in speech, occupational or physical therapy before? \_\_\_yes \_\_\_no

If yes, where: \_\_\_\_\_

**Therapy Goals:**

What is your goal for your child to achieve in therapy? \_\_\_\_\_

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What have you been told by doctors, teachers and other professionals about your child? \_\_\_\_\_

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**Developmental Milestones:**

As best as you can remember list the age at which each skill was accomplished by your child.

**Motor:**

Sitting alone: _____	Reaching for objects: _____
Pulling to stand: _____	Finger feeding: _____
Walking: _____	Eating with spoon: _____
Jumping: _____	Drawing on paper: _____
Riding tricycle: _____	Cutting with scissors: _____
Skipping: _____	Using knife for food: _____

**Language:**

Did/Does your child:

Respond to his/her name: \_\_\_yes \_\_\_no

Babble or make a combination of sounds \_\_\_yes \_\_\_no

Age he/she said first word: \_\_\_\_\_ Combined words: \_\_\_\_\_

How does your child let you know what he/she wants?

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Are you able to understand your child's speech? \_\_\_yes \_\_\_no

Are other people able to understand your child's speech? \_\_\_yes \_\_\_no

**Self-Help:**

Does your child dress independently? \_\_\_\_\_

Does your child bathe independently? \_\_\_\_\_

Is your child toilet trained? \_\_\_\_\_ independent using toilet \_\_\_\_\_

Is your child able to complete the following skills, answer yes or no.

Pull off: socks \_\_\_\_\_ shirt \_\_\_\_\_ pants \_\_\_\_\_ shoes \_\_\_\_\_

Put on: socks \_\_\_\_\_ shirt \_\_\_\_\_ pants \_\_\_\_\_ shoes \_\_\_\_\_

Zippers        yes \_\_\_\_\_    no \_\_\_\_\_        Buttons                yes \_\_\_\_\_    no \_\_\_\_\_

Snaps            yes \_\_\_\_\_    no \_\_\_\_\_        Shoe tying            yes \_\_\_\_\_    no \_\_\_\_\_

**Social History:**

Does your child make friends easily? \_\_\_\_\_

How does your child play with other children (aggressive, picked on, loner, leader etc)?  
\_\_\_\_\_

Is your child difficult to discipline? What is your approach to behavior problems?  
\_\_\_\_\_

Do you have any concerns about your child's social or play skills?  
\_\_\_\_\_

**Sensory History:**

Does your child:

Yes/No

Explain

1. Get carsick easily \_\_\_\_\_
2. Enjoy swinging/sliding etc \_\_\_\_\_
3. Spin around more than others \_\_\_\_\_
4. Seem fearful of climbing \_\_\_\_\_
5. Dislike being hugged or held \_\_\_\_\_
6. Dislike touch from others \_\_\_\_\_
7. Seem picky about clothing \_\_\_\_\_
8. Prefer long pants and long sleeves \_\_\_\_\_
9. Seem to be a picky eater \_\_\_\_\_
10. Avoid getting hands messy \_\_\_\_\_
11. Dislike hair cuts \_\_\_\_\_
12. Dislike tooth brushing \_\_\_\_\_
13. Frequently fall \_\_\_\_\_
14. Have poor eye contact \_\_\_\_\_
15. Respond negatively to loud noises \_\_\_\_\_
16. Have trouble functioning if lot of noise present \_\_\_\_\_
17. Not appear to hear when his/her name called \_\_\_\_\_

Please let us know anything else that concerns you or you feel would help us serve your child

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent signature \_\_\_\_\_ Date: \_\_\_\_\_