Coastside Pediatric Therapy Center

Date: _____

BACKGROUND INFORMATION

Child's Name: _____ Parent's Name: _____

Diagnosis: _____ Date of Birth: _____

Sex: M F Age: _____ E-mail Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Gestational History

Length of Gestation: _____ Medications/Alcohol during pregnancy: ☐ Yes ☐ No

Mother's Illness/Hospitalization/Falls: _____

Other Concerns: _____

Labor

☐ Spontaneous ☐ Induced ☐ Medications/anesthesia

☐ Fetal monitor in place ☐ C-Section ☐ Other Concerns

Duration of labor: _____ If induced, length of time on Pitocin: _____

☐ Fetal distress noted ☐ Suction ☐ Forceps required Birth weight: _____

Delivery

Problems breathing: ☐ Yes ☐ No

Problems sucking at birth: ☐ Yes ☐ No

By day 3: ☐ Yes ☐ No

Oxygen required: ☐ Yes ☐ No Duration of oxygen used: _____

Fed via: ☐ Breast ☐ Bottle ☐ Non-oral

If bottle: Type: ☐ Gravity flow ☐ Negative flow

Nipple: ☐ Preemie ☐ Regular ☐ Enlarged Hole ☐ Crosscut ☐ Haberman

Jaundice: ☐ Yes ☐ No Treatment: _____ Duration: _____

APGARS: _____ Tones: _____

☐ Other concerns ☐ Gastrointestinal ☐ Circulatory ☐ Respiratory

Did the newborn have immediate physical contact with mother? ☐ Yes ☐ No

Was there a positive bonding experience between mother and newborn at birth? ☐ Yes ☐ No

Was there any separation from mother during the first days? ☐ Yes ☐ No

Did mother experience any post-partum depression? ☐ Yes ☐ No

Family History

Father's
Name: _____ Age: _____ Occupation: _____ Education: _____
Mother's
Name: _____ Age: _____ Occupation: _____ Education: _____

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Is child adopted? ☐ Yes ☐ No If so, when? _____

Other Family Members

Name: _____ Age: _____ Relationship to Child: _____

_____ _____ _____

_____ _____ _____

How would you describe your child's general adjustment at home? _____

Developmental History

Age when crawled: _____ In usual manner? ☐ Yes ☐ No If not, how? _____

Age started walking: _____ Frequent stumbles and falls? ☐ Yes ☐ No

Age when siblings walked: _____

Speech development: First words: _____ First sentence: _____

Was speech reasonably normal and easily understood? ☐ Yes ☐ No

Familial Handedness: Father: ☐ R ☐ L Mother: ☐ R ☐ L Others: ☐ R ☐ L

Age potty trained: _____ Colic or "fussy baby"? ☐ Yes ☐ No

Sleeping position as an Infant: ☐ On back ☐ On side ☐ On tummy

Did child use a walker (rolling plastic seat)? ☐ Yes ☐ No If so, how often? _____

Medical History

Does child have history of seizures? ☐ Yes ☐ No Type: _____ Medication: _____

Does child have allergies? ☐ Yes ☐ No To what? _____ Medication: _____

Does child have any eating problems? ☐ Yes ☐ No

If yes, please explain:_____

Does child have sleep or bedtime problems? ☐ Yes ☐ No

If yes, please explain: _____

Illnesses/Hospitalizations/Operations? ☐ Yes ☐ No High fevers? ☐ Yes ☐ No
If so, describe:

_____

Ear infections? ☐ Yes ☐ No How treated? _____

Frequent falls? ☐ Yes ☐ No Fractures (skull, limb) ☐ Yes ☐ No

Upper respiratory infections (Bronchitis/Pneumonia/Asthma) ☐ Yes ☐ No

Seizures ☐ Yes ☐ No Epilepsy ☐ Yes ☐ No

Nightmares ☐ Yes ☐ No Bedwetting ☐ Yes ☐ No

Nail Biting ☐ Yes ☐ No

Current medications: _____ Purpose: _____ When taken: _____

Current Physician: _____

Date of last medical checkup: _____ Height: _____ Weight: _____

Are there any medical precautions the therapist should be aware of when working with your child? ☐ Yes ☐ No

If yes, please explain: _____

Other Family Members Have Had:

Speech/Language Problems ☐ Yes ☐ No Learning Problems ☐ Yes ☐ No

Hearing Impairments ☐ Yes ☐ No Behavior Problems ☐ Yes ☐ No

Allergies ☐ Yes ☐ No Neurological Problems ☐ Yes ☐ No

Chronic Illnesses ☐ Yes ☐ No Others: _____

Educational History

Current Grade: _____

Did your child attend preschool? ☐ Yes ☐ No Where? _____

Elementary school history: _____

School presently attending: _____

Special class: ☐ Yes ☐ No Teacher: _____

Initial school adjustment: _____

At school, is your child considered to be having difficulty with any of the following:

Reading	☐ Yes ☐ No	Handwriting	☐ Yes ☐ No
Following directions	☐ Yes ☐ No	Math	☐ Yes ☐ No
Finishing tasks	☐ Yes ☐ No	Spelling	☐ Yes ☐ No
Remembering information	☐ Yes ☐ No	Playground participation	☐ Yes ☐ No

Personality Profile

What are your child's gifts/strengths? _____

_____

What do you enjoy most about your child and family? _____

_____

What are your child's favorite activities, subjects at school, sports, hobbies? _____

_____

What are the presenting problems for your child? (All categories may not apply).

Academic: _____

Relationships: _____

Sensory: _____

Motor: _____

Play: _____

What things does your child tend to fear or avoid? _____

Referral Source (How were you referred to this office): _____

Checklist #1

These garments bother my child:

1. ☐Seams in clothing
2. ☐Tags in clothing
3. ☐Socks
4. ☐Changing from long to short pants
5. ☐Accessories (e.g., watch, jewelry, scarf, hats)
6. ☐Elastic on clothing
7. ☐Fuzzy or furry textured clothes (e.g., sweaters, collars, etc.)
8. ☐Wool clothes

These aspects of self-care bother my child:

9. ☐Washing or wiping face
10. ☐Cutting toenails or fingernails
11. ☐Having haircut or hair clipped
12. ☐Hair washing or drying
13. ☐Hair brushing or combing
14. ☐Getting dressed
15. ☐Brushing teeth
16. ☐Getting dirty
17. ☐Having crumbs around my mouth
18. ☐Having messy hands
19. ☐Having a messy mouth

These tactile sensations bother my child:

20. ☐Mud
21. ☐Finger paint
22. ☐Glue
23. ☐Play Dough
24. ☐Foods
25. ☐Hair care products (greasy/sticky)
26. ☐Kissing
27. ☐Coarse carpet
28. ☐Light stroking touch

These visual sensations bother my child:

29. ☐Brightly colored or patterned materials (e.g. clothes, upholstery, drapes, wallpaper)
30. ☐Fluorescent lights
31. ☐Fast moving images in the movies or TV
32. ☐Visually cluttered environments
33. ☐Busy pictures in books or complex and busy images in artwork

These smells bother my child:

34. ☐Perfume/cologne
35. ☐Cleaners/disinfectants
36. ☐Bath products
37. ☐Soaps
38. ☐Air fresheners

These aspects of food and eating bother my child:

39. ☐Salty foods (e.g., nuts or chips)
40. ☐Soft foods
41. ☐Lumpy foods
42. ☐Slimy foods
43. ☐Soup with vegetables or meat pieces
44. ☐Spicy foods (e.g., spicy dip, hot sauce)
45. ☐Eating bread crust
46. ☐Food preparation/cooking
47. ☐New/unfamiliar foods

These sounds bother my child:

48. ☐Sound of utensils against each other (e.g., spoon in bowl, knife on plate)
49. ☐Clothing that makes noise (e.g., swishing cloth, accessories)
50. ☐Doorbell ringing
51. ☐Dog barking
52. ☐Sirens
53. ☐Alarms
54. ☐Radio or TV in the background
55. ☐Fluorescent lights

56. ☐Someone talking when I am trying to concentrate
57. ☐Clock ticking
58. ☐Construction or landscaping equipment
59. ☐Water running or dripping in the background

Sounds in these places bother my child:

60. ☐Toilet flushing in the bathroom
61. ☐Appliances/small motor noises (e.g., blender, vacuum, hair dryer, electric shaver) at home
62. ☐Concerts
63. ☐Large gatherings
64. ☐Restaurants
65. ☐Parades
66. ☐Malls
67. ☐Gymnasium

These aspects related to movement bother my child:

68. ☐Climbing activities
69. ☐Walking or climbing up open stairs
70. ☐Experiencing heights
71. ☐Walking or standing on moving surfaces
72. ☐Playing in the playground jungle gym
73. ☐Playing in the playground swings and slides
74. ☐Going on amusement park rides
75. ☐Going up or down escalators
76. ☐Chewing foods

Checklist #2

Typically my child has a less intense response than others to:

1. ☐The doctor giving him/her a shot
2. ☐Bruises or cuts
3. ☐Hurting self
4. ☐Being touched on the arm or back (ex. unaware)
5. ☐Wet or dirty diapers
6. ☐Dirt on himself/herself
7. ☐Objects that are too hot or too cold to touch
8. ☐Bumping into things or falling over objects

Typically my child does not notice:

9. ☐Food or liquid left on lips
10. ☐Hands or face that are messy/dirty
11. ☐Drooling or food that has fallen out of mouth
12. ☐The need to use the toilet
13. ☐Feelings of hunger (does not seek food when hungry)
14. ☐Over-filling mouth when eating
15. ☐Feelings of being "full" (must intervene to stop over eating)
16. ☐Strong or noxious odors

Typically my child does not notice:

17. ☐Activity within a busy environment
18. ☐An object coming toward eyes quickly
19. ☐Someone entering or leaving the room
20. ☐Materials or people in the room needed to complete an activity

Typically my child does not respond:

21. ☐ When name is called or has to be touched to gain attention (hearing is ok)
22. ☐When a new sound is introduced
23. ☐To unexpected loud sounds (e.g. fire drills, hall bells or other loud noises)
24. ☐When given directions or instructions only once
25. ☐To a normal volume speaking voice (e.g., others speak loudly to gain his/her attention)

My child:

26. ☐Performs movements in a slow and plodding fashion
27. ☐Gives little indication of like or dislike from movement
28. ☐Appears to be in his/her own world (tuned out)
29. ☐Does not visually scan the environment (look around)
30. ☐Leaves clothing twisted on body

Checklist #3

My child has a constant desire for:

1. ☐Swinging
2. ☐Being upside down
3. ☐Jumping and crashing (e.g. beds or other surfaces)
4. ☐Bumping, pushing or hitting other children
5. ☐Fidgeting, wiggling and restlessness which interferes with daily routines (ex. Can't sit still, fidgets)
6. ☐Twirling/spinning throughout the day (ex. likes dizzy feeling or does not get dizzy)
7. ☐Movement in chair during class, at a meal, or a business meeting
8. ☐Deliberately falling when running or playing
9. ☐Movement without regard to safety (ex. climbs high into a tree, jumps off tall furniture)
10. ☐Bumping or pushing body against objects/walls
11. ☐Flapping or clapping hands, biting self or other repetitive actions
12. ☐Changing from one activity to another so that it interferes with completion of activities
13. ☐Pushing, pulling and hanging off things (e.g. refrigerator doors, cabinets, parents hands)

My child has a constant desire for:

14. ☐Looking at spinning objects (ex. ceiling fans, toys with wheels, floor fans)
15. ☐Watching fast changing TV or movie segments
16. ☐Watching flickering or blinking lights
17. ☐Watching visually stimulating scenarios (ex. aquarium)
18. ☐Staring at people or objects

My child has a constant desire for:

19. ☐Touching people to the point of irritating others (gets in others personal space)
20. ☐Being overly affectionate with others
21. ☐Feeling vibrations (e.g. stereo speakers, washer, dryer)
22. ☐Touching/feeling objects
23. ☐Being held
24. ☐Banging head, biting hands, pinching, scratching or pulling hair
25. ☐Splashing excessively during bath time

My child has a constant desire for:

26. ☐Licking, sucking, or chewing on non-food items (e.g. hair, pencils, clothing)
27. ☐Eating crunchy, chewy or hard foods to the exclusion of other textures
28. ☐Putting things in mouth
29. ☐Excessive kissing

My child has a constant desire to:

30. ☐Eating foods with strong flavors/tastes (ex. bitter, sour, spicy)
31. ☐Smell people/pets
32. ☐Deliberately smelling or tasting objects or toys during play or other activities

My child has a constant desire to:

33. ☐Talk and has difficulty taking turns
34. ☐Speak in a loud voice
35. ☐Making a lot of noises during play activity
36. ☐Increase the volume on the TV, CD, or radio
37. ☐Make strange sounds

Checklist #4

My child does not:

1. ☐Have a preferred hand (after age four) for writing, cutting, etc.
2. ☐Does not hold paper with other hand while cutting or writing
3. ☐Reach across his/her body to grab a toy

My child does not have adequate strength so he/she:

4. ☐Has difficulty turning knobs or handles that requires some pressure
5. ☐Has a loose grasp on objects i.e. pencil, scissors, or things that he is carrying
6. ☐Has a rather tight, tense grasp on objects but cannot sustain
7. ☐Can't lift heavy objects
8. ☐Seems weaker than other children his/her age
9. ☐Hold a pencil differently from most people

My child has difficulty in these activities:

10. ☐Balancing when a bus, car, or subway stops quickly
11. ☐Balancing during motor activities (ex. Biking, karate, gymnastics, etc.)
12. ☐Keeping good desk posture (slumps, leans on arm, head too close to work, props head on hand)
13. ☐Turns head alone (turns whole body to look at you)
14. ☐Tires easily, especially when standing or holding particular body position
15. ☐Catching self when falling

My child:

16. ☐Feels stiff and awkward when held
17. ☐Keeps mouth open most of the time
18. ☐Tires easily
19. ☐Sits partly on and off the chair
20. ☐Feels "loose" or "floppy" when you lift him/her up or move the child's limbs to help him get dressed
21. ☐Uses one hand or the other but avoids play with the hands together
22. ☐Avoids or needs encouragement for any heavy work (ex. pushing, pulling, lifting)

My child has difficulty coordinating 2 sides of the body to:

23. ☐Play rhythmic clapping games
24. ☐Pump self on swing
25. ☐Jump with both feet together
26. ☐Ride a bicycle, tricycle or big wheels

My child has difficulty with the following visual activities:

27. ☐Keeping track of place on page (ex. reading)
28. ☐Following a moving object with eyes, copying from blackboard to paper

Checklist #5

My child has difficulty in these language activities:

1. ☐Is hard to understand when s/he speaks (speech/articulation problems)
2. ☐Unable to follow two or three step directions

My child has difficulty with these motor activities:

3. ☐Tasks that have several steps
4. ☐Learning exercise steps or routines
5. ☐Learning new motor tasks
6. ☐Following the steps of a recipe
7. ☐Maintaining or copying rhythms
8. ☐Balancing
9. ☐Hopping, jumping, skipping, or running compared to others his/her age
10. ☐Climbing/jumping or walking on bumpy/uneven ground
11. ☐Sports or games
12. ☐Climbing on or over objects
13. ☐Riding a bike, tricycle or big wheel (pedaling or pushing with feet)
14. ☐Climbing or playing on playground equipment
15. ☐Catching a ball

My child:

16. ☐Is clumsy or seems to not know how to move body, bumps into things
17. ☐Prefers sedentary (quiet) activities to movement activities
18. ☐Approaches new motor activities in an overly cautious manner
19. ☐Gets lost easily (even in familiar place)
20. ☐Is accident prone
21. ☐Talks self through tasks
22. ☐Uses inefficient ways of doing things (ex. wastes time, moves slowly, does things in the hardest way)
23. ☐Tends to break toys/objects and other things when he/she has problems using them
24. ☐Has difficulty formulating goals (ideas) for action

My child has difficulty with these fine motor activities:

25. ☐Playing with small manipulative toys (ex. duplos, beads, blocks)
26. ☐Blowing (ex. soap bubbles or whistle)
27. ☐Wrapping a present
28. ☐Snapping fingers
29. ☐Operating a manual can opener
30. ☐Putting a belt through all belt loops

31. ☐Grasping a pencil or crayon
32. ☐Applying paste to toothbrush

My child has difficulty with these school activities:

33. ☐Drawing, coloring, or copying
34. ☐Cutting and pasting
35. ☐Staying between the lines when coloring or when writing
36. ☐Poor handwriting

My child has difficulty with these daily living tasks:

37. ☐Licking an ice cream cone
38. ☐Using a spoon or cup
39. ☐Handling eating utensils
40. ☐Clothing off or on
41. ☐Placing arm or leg correctly in clothing
42. ☐Tying shoes
43. ☐Fasteners (ex. buttons, zipper, snaps, buckles)
44. ☐Putting on pierced earrings and/or a necklace
45. ☐Putting on a watch

My child:

46. ☐Eats in a messy, sloppy manner
47. ☐Eats or dresses slowly
48. ☐Puts clothes on backwards or inside out
49. ☐Looks disheveled

Checklist #6

My child has trouble finding:

1. ☐Utensils on the table or in the sink
2. ☐Desired item in drawer or on shelf
3. ☐Desired garment in closet or shirt in drawer
4. ☐Socks that match
5. ☐Objects in distracting backgrounds (ex. shoes in messy room, favorite toy in "junk drawer")
6. ☐Printed figures that appear similar (ex. b and dp, or + and x)
7. ☐A familiar face in a crowd
8. ☐The appropriate aisle in a store
9. ☐Information on a blackboard and copying it to his/her paper
10. ☐Things that are moving from those that are not moving

My child has trouble judging:

11. ☐The amount of force needed for a task (ex. Pushing grocery cart, kicking a ball)
12. ☐Appropriate pressure with markers, crayons and glue sticks (w/o breaking or fattening)
13. ☐Timing and distance (difficulty catching, batting a ball or throwing to a target)
14. ☐If he/she is moving or if things around him/her are moving
15. ☐Where food is within the mouth (ex. doesn't chew fully before swallowing)

My child has trouble distinguishing (without looking):

16. ☐Objects in pocket, purse or drawer by feel
17. ☐What is in his hands
18. ☐What is touching him
19. ☐Buttons and button holes

My child:

20. ☐Tends to examine toys by touching and feeling them rather than looking at them
21. ☐Continues to examine objects by putting in the mouth (past age of 1.5 years)

My child has trouble distinguishing:

22. ☐The location of sounds
23. ☐What is said
24. ☐The words to a song when listening to a radio
25. ☐Specific sounds that are similar (ex. caT vs. caP or back vs. baT)
26. ☐The taste of different food

Social Emotional Development

Please give your answers based on the child's behavior over the past 6 months or school year.

	Yes	No
Has at least one good friend		
Plays cooperatively with peers		
Usually follows directions from adults		
Adapts well to changes in routine		
Asks for help when having difficulty		
Gets upset easily		
Able to calm self or be calmed when upset		
Often gets in trouble at daycare / school / another structured environment		
Is comfortable trying new activities		
Proud of accomplishments		

Comments (*optional)*: _____

_____

_____

Personal Care

Please indicate the child's ability level for the following personal care skills.

Activities of Daily Living	Independent	Needs Supervision or Assistance	Dependent	Comments
Bathing self				
Brushing hair				
Brushing teeth				
Dress upper/lower body				
Use the toilet				
Feed self				

Interoception

Does your child have difficulty with noticing any of the following?

☐ Sleep

Ex. My child misses the early signs of feeling sleepy.
Ex. My child struggles to help their body feel calm when time to go to sleep.

Comment: _____

☐ Toileting

Ex. My child needs to be reminded to go to the bathroom even after long periods of time.
Ex. My child appears to feel the need to urinate or defecate more frequently than others their age.

Comment: _____

☐ Fullness

Ex. My child eats very small quantities of food compared to others of the same age.
Ex. My child seems to get full very quickly even from small quantities of food.
Ex. My child doesn't recognize when hungry.

Comment: _____

☐ Thirst

Ex. My child needs to be reminded to drink, otherwise they might forget.
Ex. My child appears to feel thirst more frequently than others of their age.

Comment: _____

☐ Physical Exhaustion

Ex. My child over-exerts, exercises, or plays well beyond point of exhaustion.
Ex. My child complains about their body during exercise or play even when it is not overly strenuous.
Comment: _____

☐ Illness

Ex. My child has a hard time identifying when they are sick.
Ex. My child notices when they are sick but has a difficult time identifying what is wrong (symptoms).
Ex. My child worries over even the smallest body signals, often interpreting them as a sign of illness.

Comment: _____

☐ Hot/Cold

Ex. My child does not realize when they are getting overheated.
Ex. My child is seemingly unaffected by hot or cold weather. They can go outside while wearing clothing not appropriate for the weather.
Comment: _____

Oral Motor History

Food Tolerance

☐ Cold	☐ Crunchy	☐ Grainy	☐ Bitter
☐ Hot	☐ Thick food/fluid	☐ Sweet	☐ Salty
☐ Chewy	☐ Thin food/fluid	☐ Sour	

Food Intake

Method: ☐ Breast ☐ Bottle – Type: _____ ☐ Nipple – Type: _____

Position: _____ Average intake per day: _____

Average intake per feeding: _____ oz. in _____ minutes

Type of formula: _____

Constipation? ☐ Yes ☐ No How treated? _____

Reflux? ☐ Yes ☐ No How treated? _____

Solids	Age		Age
Cereal from a spoon		Pureed fruits/veggies	
Pureed meats		1/2 in. size pieces	
1/4 in size pieces		Raw fruits and veggies	
Regular meats			

Liquids	Age	**Others**	Age
Cup without lid or spout		Thumb sucking	
Straw		Pacifier type	
Ended use of bottle		Ended use of pacifier	

Oral Health/Development

When did teeth erupt? Gagging? ☐ Yes ☐ No

Bruxism: ☐ Yes ☐ No Frequency: _____ AM/PM/BOTH Positional Relationship: _____

Drooling: ☐ Yes ☐ No Frequency: _____ AM/PM/BOTH Positional Relationship: _____

Sloppy eater? ☐ Yes ☐ No

Tolerance of tooth brushing: _____ Tolerance of touch to face and head: _____

Last visit to dentist? _____ Findings: _____

PREVIOUS TESTING AND TREATMENT

Has your child had any previous ASSESSMENT or TREATMENT? **Please attach relevant reports.**

Medical: _____

Audiological: _____

Speech: _____

Educational: _____

Psychological: _____

Occupational Therapy: _____

Vision: _____

Other: _____

Comments: _____

Has there been any specific events or traumas linked with the onset of your child's difficulties?

_____

Is your marital situation stable and positive at this time? _____

What, if any, stresses are affecting your family at this time? _____

Are there other individuals or family members living at home? (Other than immediate family)

_____

GOALS

What are your goals for your child's program? Please be as specific as possible.

1. _____
2. _____
3. _____
4. _____
5. _____