sensory in motion
therapy services

Child and Adolescent History Form

Today's Date: Completed by:

Child's Full Name: Date of Birth:

Child's Preferred Name: Age: Sex: M F

Child's Address:

School: Grade:

Pediatrician: Referred by:

Medications: Allergies:

Family and Contact Information

Parent A's Name: Parent B's Name:

Home Phone: Home Phone:

Cell Phone: Cell Phone:

Email Address: Email Address:

Physical Address: Physical Address:

Relationship to Child: Relationship to Child:

Preferred Contact Number:

Emergency Contact (Name, Number, Relationship):

	Name:	Age:	Sex:	Adopted?	Profession/School:
Mother:			M or F	Y or N	
Father:			M or F	Y or N	
Sibling:			M or F	Y or N	
Sibling:			M or F	Y or N	
			M or F	Y or N	

Who Does the Child Live With: Parent's Marital Status:

Have there been any traumatic family events in the course of this child's development?

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

sensory in motion
therapy services

Areas of Concern and Goals

My primary area(s) of concern at this time is/are (check all that apply):

__Feeding __Sensory __Fine Motor __Coordination __Social Skills __Visual Motor

____Academics ____Activities of Daily Living ____Other:_____

Please describe, in your own words, what your currents concerns for your child are at this time (i.e. related to academics, activities of daily living, relationships, sensory, speech, motor, play, feeding):_____

_____

_____

_____

How can we be most helpful to you and your child?_____

_____

_____

What are your goals for your child?

Academic:_____

Personal:_____

Social:_____

Other:_____

Pregnancy and Birth History

If child is adopted, please report all that is known.

PRENATAL HISTORY

What kind of experience was the pregnancy for both parents?
Mother:_____
Father:_____

Please check all that apply to the pregnancy:
__Planned __Unplanned __High Risk Pregnancy __Complications Present __Previous Miscarriage(s) __Use of Fertility Treatment

Please describe any complications or reasons for high risk classification:_____
_____

Please check all that apply to Mom during pregnancy:
__Mother talked/sang __Mother was physically active __Experienced loss of a loved one during pregnancy __Diagnosis of Gestational Diabetes __Diagnosis of Preeclampsia __Experienced Depression __Experienced Anxiety __Confined to bed __Smoked __Consumed Alcohol __Consumed Drugs __Took Medications (Type):_____

LABOR AND DELIVERY
Describe your/the mother's experience during labor and delivery:_____
_____

Description	No	Yes	Explanation/Comments
Born Full Term			
Forceps Used			
Caesarean Birth			
Were there any complications?			
Did baby cry immediately?			
Was special treatment required (oxygen, jaundice, IV treatment, etc.)?			
Required care in the NICU?			
Diagnosed disability at birth?			
Did mother and newborn have immediate contact?			
Was there positive bonding between mother and newborn?			
Was the newborn breastfed?			
Any separations between mother and newborn in 1st few days of life?			
Did mother experience post partum depression?			

Birth weight:_____ Apgar Scores:_____

Adoption/Foster Care History

Skip this section if child is biological.
Describe the circumstances surrounding the adoption/foster care._____
_____
Age when adopted?_____
Prior foster homes? _____
Physical appearance: _____
Response to new home:_____
Is the child aware of the adoption? _____

Health History

INFANCY
Going back to the first two years of the child's life, what type of baby was he/she (feeding, sleeping, activity level, demeanor)?_____

	Yes	No	Explanation (if needed):
Any extended separations over the first 2 years of life?			
Feeding Problems?			
Sleeping Problems?			
Specific Health Problems?			
Quiet?			

Fussy?			

CHILDHOOD HEALTH HISTORY

Has he/she ever been hospitalized? Yes_____ No_____
If yes, please describe:_____
Has he/she had any surgeries or a serious accident/injury? Yes ____ No_____
If yes, briefly describe:_____

Has your child had any of the following childhood illnesses/problems? In your explanation for any questions answered "yes," please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

Description	**Yes**	**No**	**Explanation:**
Ear infections			None/Few/Frequent
Respiratory Problems			
High Fevers			
Seizures			
Meningitis			
Adenoid/Tonsil Problems			
Frequent Colds			
Allergies			Environmental/Food
Bed Wetting			
Reflux			
Gastrointestinal Problems			
Asthma			
Skin Problems			
Nightmares			
Nail Biting			
Anxiety			
Depression			
Hearing Loss			
Visual Disorder/Problems			
Joint or bone problems			
Bone Fractures			

Are there any other medical illnesses or conditions which have been diagnosed?_____
_____

PRESENT HEALTH

Is your child in good general health at the present time? Please describe any current medical/health issues._____
Has your child been diagnosed as having a specific disorder? If so, what & when?_____
_____
Is your child currently taking any prescribed medication? If yes, please describe._____

_____

Developmental History

Sensory and Motor Development

How would you describe your child's motor development? __Normal __Delayed __Advanced

How would you describe your child's hand skills? __Normal __Delayed __Advanced

Does your child walk on his/her toes? __Yes __No

At what age did your child first:

Sit up without support?	
Crawl?	
Walk?	

Color inside the lines?	
Use scissors?	
Write their name?	

What is your child's hand preference? __Right __Left __Mixed

Is your child unusually sensitive to touch or are some clothes "scratchy"? If yes, please describe:

_____

How would you describe your child's general coordination? __Good __Fair __Poor

How would you describe your child's general balance? __Good __Fair __Poor

Does your child participate in sports? Type?_____

Visual Development

Has your child experienced any problems with his/her eyesight or vision?_____

_____

Does your child wear glasses? If yes, for what correction?_____

Does your child have any sensitivities to light? If so, describe._____

When was the last time his/her eyesight was tested?_____

Auditory Development

Has your child experienced any problems with his/her hearing (operations, infections, PE tubes)?_____

Does your child have any auditory sensitivities? If so, please describe._____

_____

When was the last time his/her hearing was tested?_____

Self Care Development

Does your child eat a limited or special diet? If so, please describe._____

_____

Does your child avoid eating foods with certain textures? If so, please describe._____

_____

sensory in motion
therapy services

Please complete the following chart indicating whether or not your child is able to complete the following self-care skills independently and, if not, the amount of assistance needed. If self-care is of concern to you, please ask for and complete a detailed self-care chart.

Skill	Yes	No	Assistance Needed
Feed Self			0% 25% 50% 75% 100%
Take off shirt/pants			0% 25% 50% 75% 100%
Put on shirt/pants			0% 25% 50% 75% 100%
Take off/put on socks/shoes			0% 25% 50% 75% 100%
Potty Trained/Using the bathroom			0% 25% 50% 75% 100%
Button/Zip Clothing			0% 25% 50% 75% 100%
Tie Shoes			0% 25% 50% 75% 100%
Bath Self			0% 25% 50% 75% 100%

Speech and Language Development

How would you describe your child's speech and language development? __Typical __Delayed

Does your child have any speech difficulties? If yes, please describe. _____

_____

How does your child communicate (verbally, sign language, device, etc.)?_____

Does your child have difficulty following verbally given directions? __Yes __No

Previous Assessments/Treatment

Has your child had any previous assessments or treatment?

Type:	Yes	No	Date/Place/Reason
Audiological			
Psychological			
Neurological			
Genetic Testing			
Diagnostic Testing			
Occupational Therapy			
Physical Therapy			
Speech Therapy			

Education

Where does your child currently attend school? Who is his/her teacher?_____

_____

Please describe any concerns shared by the teacher._____

_____

How would you describe your child's experience at school?_____

_____

Has your child received any remedial help given at school? ___Yes ___No

Has your child received any remedial help outside of the school? ___Yes ___No

Does your child have an IEP in place? ___Yes ___No

Behavior/Character

How would you describe your child?_____

What are your child's strengths?_____

What are your child's weaknesses?_____

Have there been any specific behavior problems in the course of your child's development?

_____

What kind of interests and activities does your child have (hobbies, sports, clubs, etc)?

_____

How would you describe your child's social adjustment:

With peers?_____

With adults?_____

Are there any other concerns/pertinent information you would like to share that was not included on this form?_____

_____

_____

_____

_____