

SENSORY MOTOR AND MEDICAL HISTORY FORM
(12 months to 36 months)

Please fill in the questionnaire as completely as possible. Return the completed form 48 hours before beginning services.

GENERAL INFORMATION

Child's Name: _____

Birth Date: _____ Age: _____ Sex: _____

Reason for referral: _____

Who referred you to our practice: _____

Parent Name: _____

Education: _____ Occupation: _____

Parent Name: _____

Education: _____ Occupation: _____

Marital Status: Married Partner Separated Divorced Widowed Single

PRENATAL AND NATAL HISTORY

Is he/she your biological child? Yes No If no, please explain: _____

Is child adopted? Yes No If yes, at what age? _____

Full Term: _____ (38 to 42 weeks)

Premature: _____ (before 37 weeks) How many weeks? _____

Birth Weight: ___ lbs ___ oz Birth Length: _____

Please check any problems encountered during pregnancy?

Injuries Stress Bleeding Anemia Placenta Previa

Preeclampsia High blood pressure Anxiety/Depression

Other (illnesses, seizures, etc.): _____

Diet during pregnancy: regular vegetarian vegan

Prenatal vitamins? Yes No

Additional supplements? Yes No If yes, what? _____

Medications taken during pregnancy: _____

Is this your first child? Yes No

Delivery (check all that apply): Vaginal Forceps and/or Vacuum Extraction

Induction Planned C-Section Emergency C-Section

What kind of anesthesia? _____

Problems with labor (check all that apply)? Yes No

Breech Limpness Stiffness Breathing Issues

At the time of delivery, did you infant have trouble with any of the following (check all that apply):

Cyanosis Jaundice Pallor Heart rate Reflexes Breathing

___ Congenital defects ___ Infantile spasms/seizures

Was there a need for any of the following?

___ Oxygen ___ Transfusions ___ Tube Feedings ___ CPAP ___ Ventilator

Were there any feeding difficulties after birth? Yes No

Please explain: _____

___ Bottle Fed ___ Breast Fed ___ Combination

Did your baby go home from the hospital with you? Yes No

Length of hospitalization: _____

GENERAL HEALTH

Immunizations Current? Yes No

If no, please list which are not up to date according to recommended schedule: _____

Feeding

Are there any feeding problems now (check all that apply)?

___ Difficulty swallowing ___ Difficulty chewing ___ Gagging/choking

___ Tube fed ___ Reflux/vomiting ___ Other _____

Reflux Medication: Yes No

Are there any bladder/bowel difficulties? Yes No Please explain: _____

Food Allergies/Sensitivities Yes No Please list: _____

Illness/Injuries

Any Other Allergies (environmental) or Asthma? Yes No Please list: _____

Any Medication(s): Yes No Please list: _____

Previous Illnesses (check all that apply):

___ RSV ___ Pneumonia ___ Bronchitis ___ BPD ___ Tonsillitis

___ Head Injuries ___ Fractures ___ Other _____

___ Seizures: When diagnosed? _____ Type? _____

Frequency _____ Medications _____

___ Ear Infections: Frequency/how many? _____

Antibiotics? Yes No How many rounds? _____

Previous Surgeries (check all that apply):

___ Ear tubes ___ G-tube ___ Heart Repair ___ Trach ___ Shunt

List dates: _____

List hospitalization dates and reasons: _____

Tests performed (check all that apply):

___ MRI ___ CT Scan ___ Ultrasound ___ Genetic testing ___ X-rays ___

___ Blood work: _____
___ Other: _____

Does your child have a diagnosis? Yes No

If yes, what is the diagnosis? _____

Who provided this diagnosis and when? _____

PHYSICIANS

Child's Regular Pediatrician:

Address: _____ City/State _____

Zip _____ Phone Number: _____

Please check all that apply:

Yes	Specialty	Reason	Result
	Neonatologist Name:		
	Lactation/Feeding Specialist Name:		
	Pediatric Neurologist Name:		
	Developmental Pediatrician Name:		
	Pulmonologist Name:		
	Gastroenterologist Name:		
	Orthopedist Name:		

ENT Name:		
Occupational Therapist Name:		
Physical Therapist Name:		
Speech Language Pathologist Name:		

Have you or are you planning to contact early intervention services? Yes No
Reason(s) seeking early intervention services:

DEVELOPMENTAL HISTORY

Sleep:

How many hours does your child sleep at night? _____

How many times does your child wake in the night? _____

Developmental Milestones:

List approximate age your baby accomplished the following:

Lifted head while on tummy _____ Rolled over _____ Sat without support _____

Belly crawled _____ Crawled on hands and knees _____ Stood Unassisted _____

Cruised _____ Walked _____

Check which of the following described your child **as an infant**:

Fussy Irritable Good Non-demanding Quiet Passive Active

Liked being held Resisted being held Floppy when held

Tense muscles when being held Good sleep patterns Irregular sleep patterns

Over-active, never still unless sleeping

Comments: _____

Speech/Language History:

Give approximate ages at which child did the following:

Babbled _____ Said first word _____

Examples of first words: _____

Combined two words _____ Give example _____

Used 3-4 word sentences _____ Give example _____

Obedied simple commands _____

PRESENT LEVEL OF FUNCTION:

Play:

With whom/who does the child spend most of his day? _____

How does your child choose to use his/her free time? _____

Does your child play appropriately with toys? Yes No

If no, explain:

Discipline:

Who is responsible for discipline/rule setting in the home: _____

What methods are used and what seems most effective? _____

How does the child react to discipline? _____

Does the child tantrum? Yes No

Have you observed any head banging or self-destructive behavior? Yes No

If yes, explain _____

Check which describes child **at present**:

- Usually happy Mostly quiet Overly active Tires easily Talks constantly
 Too impulsive Restless Stubborn Resistant to changes
 Over reacts Clumsy Wets bed Fights frequently Exhibits frequent temper tantrums
 Has difficulty separating from primary caretakers Has nervous habits or tics
 Falls often Poor attention span Easily frustrated Cries often
 Cries infrequently Rocks self frequently Has difficulty learning new task

General impression of child's motor development:

Gross Motor: Slow Normal Advanced

Fine Motor: Slow Normal Advanced

Has your child achieved some skills and lost them? Yes No

If yes, what skills?

Sensory:

Vestibular (movement and gravity information). Check which of the following apply to your child: Rocks while sitting Jumps a lot Likes being tossed in the air

Good balance Fearful of heights Fearful of movement Likes Merry-Go-Rounds

Spins & whirls more than other children Gets car sick Enjoys being rocked

Prefers quiet play as opposed to more active play No fear of movement or falling

Comments: _____

Tactile (touch information). Check which of the following apply to your child:

Avoids “messy” things (mud, finger paint, etc.) Dislikes having face washed or wiped

Irritated by cloth of certain textures Objects to being touched

Dislikes unexpected touch Avoids using hands for extended periods

Pinches, bites, or otherwise hurts him or herself Examines objects by putting them into his/her mouth Tends to feel pain less than others Isolates him or herself from other children

Excessively ticklish Dislikes hair washing Dislikes nail cutting

Wants to handle everything Seeks lots of touch Dislikes teeth brushing

Comments: _____

Proprioceptive (muscle and joint information). Check which of the following apply:

Holds hands or body in strange positions Uses too much/too little force on objects

Good coordination with small things (i.e., pencil, buttons) Is clumsy

Walks on toes (or did when younger) Went from sitting to standing with little or no crawling

Crept on tummy rather than hands or knees Leaps from one position to the next, unable to move slowly from one to another

Comments: _____

Visual: Check which of the following apply to your child:

Bothered by bright light Looks very closely and carefully at pictures or object

Becomes very excited when there is a variety of visual objects Has difficulty maintaining

eye contact with another person Difficulty following an object across the room Difficulty following an object tossed toward him/her

Comments: _____

Gustatory-Olfactory (taste and smell information). Check which of the following apply to your child: Chews on non-food objects Reacts negatively to smell Dislikes food of certain textures Has unusual cravings for certain foods

Comments: _____

Self-help Skills:

Describe degree to which child routinely performs the following:

Feeds self: All Most Some Rare

If feeds self, uses: Fingers Spoon Fork

Undresses self: All Most Some None

Dresses self: All Most Some None

Is child toilet trained? Yes No

If yes, at what age? _____

Bladder (daytime) Bladder (day & nighttime) Bowel

Speech/Language/Auditory:

Check which apply to your child's listening habits:

Responds only to loud sounds

Seems to ignore people when they are talking to him/her

Responds as if sound is painful (covering ears/crying)

Seems to hear properly

Seems uninterested

Doesn't respond to name/commands when there are other noises nearby

Makes strange noises/loud noises

Check the statements that best describe your child's ability to understand language:

Understands no spoken language

Understands a few words

Follows simple commands

- Understands most words
- Understands simple conversations
- Understands everything that is said to him/her

At present, how much of your child's speech can be understood?

By mother: All Most Some None

By other family members: All Most Some None

By neighbors: All Most Some None

If applicable, describe your child's speech challenges (give examples): _____

Is any language other than English used in the home? Yes No

If yes, what language? _____ What percent of the time? _____

Check those which describe your child's ability to use spoken language:

- Makes no sound or on a very limited basis Language is limited to gestures
- Babbles only No true words Language is limited to single words or short phrases
- Uses simple sentences Sentences are long but disorganized and hard to understand
- Repeats words often or hesitates frequently Words are difficult to understand Voice
- quality is unusual (hoarse, nasal or earthy, high pitched) Has difficulty recalling recent events
- Has trouble remembering the correct names of things Has no apparent problems
- expressing himself Seems frustrated at trying to relate events
- Stutters frequently

School/Daycare:

Is your child in a structured preschool or daycare program? Yes No

Name of school/program: _____

Are there any teacher concerns? Yes No

If yes, please explain: _____

Has your family experienced any recent crisis or major change (stress) that you feel is important to your child's development (financial problems, moves, job changes, divorce or separation, death, etc)? Please explain:

Are there any speech, physical or learning problems among family members, relatives?

Relationship to Family Member:

Describe Problem:

Who else lives in the home?

Name:

Age:

Relationship:

PARENTAL CONCERNS AND GOALS

Please list any concerns you would like to share with us regarding your child:

Your child's comprehensive **Occupational Therapy (OT) Evaluation** at Sensational Kids Therapy will assess motor skills and sensory processing/modulation. The information from this evaluation will be used to rule-in or rule-out your child's need for direct, ongoing OT services.

Please note that our OT assessments cover the areas below:

- Fine Motor Skills (grasp, dexterity, fine motor control)
- Visual Motor Skills (drawing, scissor skills, handwriting; etc.)
- Praxis/Motor Planning (includes ideation, sequencing, timing, and coordination)
- Balance (static and dynamic)
- Postural Control/Stability (flexion and extension strength)
- Bilateral Coordination
- Sensory Processing/Modulation (including tactile, auditory, visual, movement, and muscle/joint)

Your child's comprehensive **Physical Therapy (PT) Evaluation** at Sensational Kids Therapy will assess gross motor skill development and will be used to rule-in or rule-out your child's need for direct, ongoing PT services. Please note that our PT assessments cover the areas below depending on your concerns.

- Torticollis/Plagiocephaly (infants)
- Gross motor developmental delays

- Range of motion
- Muscle strength
- Walking and/or running gait
- Ball Skills

Please list 3 goals you would like your child to work on:

1. _____

2. _____

3. _____