SENSORY MOTOR AND MEDICAL HISTORY FORM

(pre-school to school age)

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? Ye☐No☐
Additional supplements? Ye☐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/school services? Yes☐No☐
Reason(s) seeking 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 child 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 _____
Obeyed 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? Ye☐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? Ye☐No☐

Have you observed any head banging or self-destructive behavior? Ye☐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

Drawing/Handwriting: ☐ Slow ☐ Normal ☐ Advanced

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

If yes, what skills?

_____

_____

Does your child show a hand preference? Yes☐No☐Please circle: Right☐Left☐

Which hand does your child use for the following activities? Feeding _____

Crayon/pencil _____ Throwing _____ Cutting _____

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 ☐ Difficulty discriminating shapes/colors ☐ Shifts head to one side to look at an object ☐ Makes reversals (ages 7+)
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

Social: Check which of the following apply to your child: ☐ Functions better on playdates than in the classroom setting ☐ Makes friends easily ☐ Prefers to play with younger children ☐ ☐Prefers to play with older children ☐ Prefers the company of adults ☐ Tends to isolate him/herself in the classroom
Comments: _____
_____
_____

School/Daycare:
What type of structured program does your child attend? (please circle)
Part-day preschool Full-day preschool/daycare Private School Public School
Name of school/program: _____
Grade: _____ Grades repeated or skipped? Yes☐No☐ _____
Is your child in a special education classroom now or in the past? Yes☐No☐
If yes, describe please list where, when, and what type of program: _____
_____
What academic skills are the hardest? _____
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:

_____

_____

_____

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

1. _____
2. _____
3. _____