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SENSORY MOTOR AND MEDICAL HISTORY FORM
(Birth to 12 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? 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)?
_☐_ Poor suck _☐_ Difficulty swallowing _☐_ Difficulty chewing _☐_ Gagging/choking
_☐_ Tube fed _☐_ Reflux/vomiting _☐_ Other _____
Reflux Medication: Yes☐No☐
Are there any bladder/bowel difficulties? Ye☐No☐Please explain: _____
_____
Nutrition (check all that apply): _☐_ Bottle _☐_ Formula _☐_ Pureed _☐_ Solids
Food Allergies/Sensitivities Yes☐No☐ Please list:
_____
_____

Illness/Injuries
Any Other Allergies (environmental) or Asthma? Yes☐No☐Please list: _____
_____
Any Medication (please list): Yes☐ No☐ Please list:
_____
_____
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? _____
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: _____

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

Tummy Time

Does your baby enjoy being on their tummy for play? Yes☐ No ☐
How long does your child play in this position? _____ minutes _____ times/day

Sleep

How many hours does your baby sleep at night? _____
How many times does your baby wake in the night? _____
How many times does your baby feed in the night? _____

Does your baby…? Please check all that currently apply
_☐_ smile in response to sound/voice _☐_ smile in response to touch
_☐_ smile in response to bottle/breast _☐_ smile in response to faces
_☐_ quiet when picked up _☐_ enjoy physical contact _☐_ enjoy being rocked
_☐__ enjoy bouncing _☐_ become bothered during car rides
_☐_ follow a person with his/her eyes _☐_ swipe at objects _☐_ coo or babble
_☐__ respond to name _☐_ use consonants (how many? ____) _☐_ follow simple directions
_☐_ open/close mouth with food stimulation _☐_ take hands to feet while on back
_☐_ roll to right back to tummy _☐_ roll to left back to tummy
_☐__ roll to right tummy to back _☐_ roll to left tummy to back
_☐_ hold toy briefly in 1 hand _☐_ hold toy briefly in 2 hands
_☐_ transfer objects from one hand to other _☐_ bring hands to the middle

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 _____

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. _____