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? 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/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? 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

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:
____
____
____

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. ____