"Now We're Talking"
Pediatric Therapy, Inc.

Developmental/ Medical History

General Information:

Date: _____ Person Completing Form: _____

Child's Name:_____ DOB:_____ Age:_____ Sex:_____

Parents/Guardians:_____

Pediatrician: _____ School/Daycare: _____

Reason for Referral:_____

Others Living in the Home:	Relationship:	Age:	History of Delays:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prenatal and Birth History

Please describe mother's general health during the pregnancy of this child (illnesses, accidents, medications, complications, etc.)

Term: Full Term: _____ Premature: _____ Length of pregnancy: _____
APGAR Scores: _____ Birth Weight: _____Hospital Stay: _____ How Long: _____

Describe any unusual conditions at or immediately after birth: _____

Medical History

Any Medical Diagnosis: _____

Check all that apply and the approximate age:

Allergies _____	Ear infections _____	Asthma _____	Pneumonia _____
Frequent Colds _____	Influenza _____	RSV _____	Croup _____
Headaches _____	Seizures _____	Tonsillitis _____	Draining Ear _____

Date of Last Hearing Test: _____

List surgeries/hospitalizations? If yes, date & type (e.g., tonsillectomy, adenoidectomy, PE tubes)?
_____

Is your child currently taking any medications? If yes, please list them.
_____

Developmental History:

Provide the approximate age at which you child began to do the following:

Speech: (babble, say 1st Words, combine words) Typical _____ Delayed _____
Fine Motor: (color, write, cut, feed/dress self) Typical _____ Delayed _____
Gross Motor: (rolling, crawling, walking) Typical _____ Delayed _____

How does your child usually communicate? (CHECK ALL MEANS OF COMMUNICATION USED BY YOUR CHILD, AND BRIEFLY DESCRIBE HOW AND WHEN THEY ARE USED)

___ Vocalizations ___ Eye gaze ___Voice output communication device
___ Words ___ Gesture System ___ Object communication system
___ Facial expressions ___ Sign Language ___ Picture communication boards

Describe your child's social/emotional skills (CHECK ALL THAT APPLY)

____ Relates well to other children ____ Easily frustrated
____ Prefers to be alone ____ Fearful of new situations
____ Aggressive ____ Immature
____ Lacks Confidence ____ Shy
____ Active ____ Poor judgment regarding personal safety

What languages does your child speak? What is the primary language spoken at home?

With whom does your child spend most of their time?

Have any other specialists (speech language pathologist, occupational therapist, physical therapist, physicians, psychologists, special education teachers, etc.) seen your child? If yes, indicate the type of specialist, when your child was seen, and the specialist's conclusions or suggestions/diagnosis?

Does your child receive any of the following services, if you check yes, please indicate where/with whom.

____ Early Intervention ____ Public School Services
____ Occupational Therapy ____ Physical Therapy
____ Speech-Language ____ Visual Impaired Services

Please describe your concerns and what your goals for your child are: _____
_____
_____
_____
_____
_____
_____