General Information

Child's Name: ______________________ Date: ______________________

Date of Birth: ______________________ Gender: ☐ Male ☐ Female

Address: ______________________ Home Phone: (____)______________________

______________________ Other Phone: (____)______________________

Child's Primary Language: ______________________ Child's Secondary Language: ______________________

Reason for Referral:

____

Referred by:

____

Parent's Primary Concern:

____

Parent Information

Guardian's Name: ______________________

Address (if different from above):

____

____

Home Phone: (____)______________________

Email Address: ______________________

Occupation: ______________________

Employer's Name: ______________________

Position / Division: ______________________

Address: ______________________

____

Phone: (____)______________________

Does your company support local charities through:

☐ Matching gifts ☐ Employee giving ☐ Community grants

Level of Education: ☐ High School ☐ College ☐ Graduate School

Guardian's Name: ______________________

Address (if different from above):

____

____

Home Phone: (____)______________________

Email Address: ______________________

Occupation: ______________________

Employer's Name: ______________________

Position / Division: ______________________

Address: ______________________

____

Phone: (____)______________________

Does your company support local charities through:

☐ Matching gifts ☐ Employee giving ☐ Community grants

Level of Education: ☐ High School ☐ College ☐ Graduate School

Medical Information

Primary Physician:

Name: ______________________________ Address:____

City & Zip code:____ Phone: (_____)_________________

Other Physicians:

Name: ______________________________ Address:____

City & Zip code:____ Phone: (_____)_________________

Name: ______________________________ Address:____

City & Zip code:____ Phone: (_____)_________________

Medical Diagnosis (if any): Check all that apply.

- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other Orthopedic Problems
- ☐ Allergies_________________________
- ☐ Down Syndrome
- ☐ Prenatal Drug Exposure
- ☐ Anxiety Disorder
- ☐ Fetal Alcohol Exposure
- ☐ Seizure Disorder
- ☐ Cardiac Condition
- ☐ Fragile X Syndrome
- ☐ Speech & Language Delay
- ☐ Cerebral Palsy
- ☐ Frequent Ear Infections
- ☐ Spina Bifida
- ☐ Developmental Delay
- ☐ Learning Disabilities
- ☐ Traumatic Brain Injury
- ☐ Developmental Coordination Disorder
- ☐ Mood Disorder (e.g. bipolar, depression)
- ☐ Tourette's Syndrome

Pervasive Developmental Disorder:

- ☐ Other Chromosomal Disorder
- ☐ Other: ____________________
- ☐ Autism Spectrum Disorder
- ☐ Asperger's Disorder
- ☐ Pervasive Developmental Delay Not otherwise specified
- ☐ Rett's Syndrome
- ☐ Childhood Disintegrative Disorder

Is your child currently receiving any medications? ☐ Yes ☐ No (Please list)

Medication: __________________________ Purpose: ___________________________ Frequency of dosage: ___________________

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Medication: __________________________ Purpose: ___________________________ Frequency of dosage: ___________________

Are there any medical precautions or allergies the therapist should be aware of when working with your child?

____

Does your child have any assistive devices (e.g. glasses, casts, wheelchair, communication devices?) ________________________________

____

Does your child have sleep problems? ☐ Yes ☐ No (Please explain)

____

Background Information

Number of children in family and ages:

____

Has your child received previous evaluation and/or treatment? ___________ If so, where: ______________________________

____

When did you first notice your child's difficulties, and how were they apparent to you?

____

____

Is anyone in the family left-handed? ☐ Yes ☐ No If so, who?_______________________________

Prenatal and Birth History

Mother's age at birth of child ____________________ Father's age at birth of child _____________________

Did the mother have any infection/illnesses during pregnancy? ☐ Yes ☐ No

Describe: ____

Did the mother have any traumatic events or unusual stresses during pregnancy? ☐ Yes ☐ No

Describe: ____

Did the mother receive any medication, other than over the counter medication, during pregnancy? ☐ Yes ☐ No

Describe: ____

Where there any complications during delivery/labor? ☐ Yes ☐ No

Describe: ____

Was the child full term ☐ Yes ☐ No Birth Weight: ______________________________

Was the child premature ☐ Yes ☐ No Number of weeks (gestational age): ___________________

Was the child breech ☐ Yes ☐ No ☐ Vaginal birth ☐ Cesarean birth

Did the child have any birth injuries: ☐ Yes ☐ No

Describe: ____

Did the child require intensive care hospitalization: ☐ Yes ☐ No

If yes, for how long?____

APGAR score, if known: _______________

Where there other complications such as (please check all that apply):

☐ breathing difficulty ☐ incubation ☐ jaundice ☐ transfusion ☐ tube fed ☐ congenital defects

Developmental History

Please provide ages as near as possible:

Rolled over: ______________ Walked: ____________ Crawled: ______________

Sat alone: ________________ Talked (simple words): __________________

Other (describe): ____

Check behaviors that described your child as an infant or your child presently:

- ☐ Cried a lot, fussy, irritable
- ☐ Resisted being held
- ☐ Good, non-demanding
- ☐ Floppy when held
- ☐ Alert
- ☐ Tense when held
- ☐ Quiet or passive
- ☐ Very active
- ☐ Liked being held
- ☐ Good sleep patterns
- ☐ Drooled excessively
- ☐ Irregular sleep patterns

Current Funding Source: ☐ **School** ☐ **Regional Center** ☐ **Insurance** ☐ **Private Pay**

Insurance Information

Subscriber's Last Name: ______________________________ First Name: ____

Subscriber's ID Number: ______________________________ Subscriber's Date of Birth: _______________________________

Primary Insurance Company's Name: _________________________________ Insurance Company Phone: _________________

Coverage Effective Date: ___________________ Group Number: __________________ Policy Number: __________________

Client's Relationship to Subscriber: ________________________________

Secondary Insurance Subscriber's Last Name (if different from above): ______________________ First Name: _____________

Subscriber's ID Number: ____________________________ Subscriber's Date of Birth: _________________________________

Secondary Insurance Company's Name: ______________________________ Insurance Company Phone: ___________________

Coverage Effective Date: __________________ Group Number: ___________________ Policy Number: ___________________

Client's Relationship to Subscriber: ________________________________