# THERAPY SPECIALISTS *of Georgia*

"Covering Everything Under the Umbrella"
4550 Arkwright Road, Macon GA 31210 O: 478-477-0601 F: 478-477-0133
Kay W. Hancock, Owner

Date _____

Person Completing Form _____ Relationship to Child _____

Child's Name _____

Date of Birth _____ Sex _____

School/Day Care_____ Grade _____

Child's Pediatrician (PCP) _____

Email: _____

Is there a language other than English spoken in the home? Yes No
If yes, which one? _____

**Briefly describe your child's problem: (reason for the evaluation)

_____

_____

## Birth History

Mother's age at birth: _____ Gestational weeks at birth: _____ Birth Weight: _____

During pregnancy did mother have: (Circle all that apply) Bleeding Anemia Diabetes Toxemia
Other:

_____

Any problems with pregnancy or delivery? Yes No C-section? Yes No Emergency C-section? Yes No

If yes, explain:

_____

Did the infant have any of the following? (Circle all that apply)

Breathing problems Oxygen given Jaundice Seizures Heart problem

NICU stay (_____days/weeks) Feeding tube( _____days/weeks) Ventilator (_____days/weeks)

How long was the child in the hospital after birth? _____

Any other problems? Yes No

If yes, please describe briefly:

_____

_____

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**General Case History**

Is the child currently taking any medications? Yes No

Please list: _____

_____

Please list any specialist your child sees: ( i.e. Orthopedist, Neurologist)

_____

Has your child had any of the following?

___ adenoidectomy ____ encephalitis ____ seizures ____ allergies ____ flu ____ breathing difficulties

____ head injury ____ high fevers ____ tonsillectomy ____ vision problems ____ ear tubes

___ ear infections, How often? _____

Medical Diagnosis:

____ Anxiety ____ Autism ____ Scoliosis _____ Learning Disorder ____ Rett Syndrome

____Down's Syndrome ____ Developmental delay ____ Sensory disorder ____ Feeding disorder

____Cerebral Palsy _____ Other: _____

Has he/she ever had a hearing evaluation/screening? Yes No
If yes, where and when? _____
Results of hearing screening: Pass / Fail

Please list any allergies your child may have: _____
_____

Please list any major hospitalizations, injuries, or accidents:

| Date | What happened? |
|---|---|
| | |
| | |
| | |

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Please list any services your child has received or is currently receiving, dates received, and where:
(School, Babies Can't Wait)

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**Development**

Does the child have/show any of the following behaviors: (Circle all that apply)

| | | | |
|---|---|---|---|
| Demands attention | Cooperative | Under active | Hyperactive |
| Short attention span | Easily managed at home | Impulsive | Aggressive |
| Nervous or sensitive | Withdrawn | Easily frustrated | Tires easily |
| Poor eater | Picky eater | Easily Distracted | Loves to cuddle |
| Overly sensitive to loud noises | Prefers to play alone | | Difficulty following directions |
| Plays well with playmates | Makes inappropriate statements | | Poor eye contact |

Other: _____

Does your child...

___ currently put toys/objects in his/her mouth?
___ brush his/her teeth and/or tolerate brushing?
___ tie his/her own shoes?
___ bathe his/her self?
___ take off/put on clothing and/or shoes?
___ have close friends?
___ get easily upset with schedule changes?
___ able to use zippers, snaps, buttons?
___ sleep through the night in their own bed?
___ enjoy bath time?
___ have a high pain tolerance?
___ scared of heights?
___ play outside?
___ get upset in crowds?

Will your child…

-Swing? Yes No -Slide? Yes No -Play in sandbox? Yes No -Walk barefoot in grass? Yes No

Please tell the approximate age your child achieved the following developmental milestones:
(if your child does not currently perform, please put n/a)

_____ sat alone _____ crawled _____ walked _____ feed self with spoon/fork

_____ grasped crayon/pencil _____ toilet trained _____dress self

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**Speech/Language Development**

Please tell the approximate age your child achieved the following developmental milestones: If unsure, please put DK for "don't know".

_____ babbled
_____ said first words
_____ put two words together (i.e. go mommy)
_____ spoke in short sentences
_____ recognize 5 colors

Does your child... check those that apply
___ repeat sounds, words or phrases over and over?
___ understand what you are saying?
___ retrieve/point to common objects upon request (ball, cup, shoe)?
___ follow simple directions ("Shut the door" or "Get your shoes")?
___ respond correctly to yes/no questions?
___ respond correctly to who/what/where/when/why questions?

Your child currently communicates using... check those that apply
___ body language.
___ sounds (vowels, grunting).
___ words (shoe, doggy, up).
___ 2 to 4 word sentences.
___ sentences longer than four words.
___ other _____

Are words used meaningfully? Yes No
About how many words does child say now? _____
Does the child presently wear a hearing aid? Yes No
Right _____ Left _____ Type of aid? _____ How long? _____

How much of the child's speech is understood by?
Family: _____ % Unfamiliar people: _____ %

Description of Speech Problems:
_____
_____

Does the child have serious difficulty in any subject/activity at school? Yes No
If yes, what subject?
_____

Is there any other information you feel would help us evaluate your child? _____
_____
_____

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**Feeding Development:**

| | |
|---|---|
| Is/Was the patient breastfed? Y/N | How Long: |
| Did/Does the patient take formula? Y/N | Type: Amount: |
| Did the patient experience Colic? Y/N | |
| Did/Does the patient take a pacifier? Y/N | What style/brand (MAM, Dollarstore, NUK, etc.): |
| The patient currently drinks from a (choose one):<br>Bottle Sippy Cup Regular Cup<br>Straw Other | Does the patient eat jar foods? Y/N<br>Any issues transitioning to jar food? Y/N<br>Stage I Stage II Stage III Graduates<br>Table Foods |
| Does the patient drool excessively? Y/N | Does the patient have preferred temperatures/textures? Y/N<br>Warm Cold Hot Room Temp |

**Family/Social History**

**Child lives with (check one):**
____Birth Parents _____Foster Parents ____One Parent
_____Adoptive Parents _____Parent and Step-Parent Other _____

**Other children in the family:**
Name Age Sex Grade Speech/Hearing Problems
_____
_____
_____
_____

FATHER'S Name _____ Age _____
(circle one) Natural Adoptive Custodial
Education _____Occupation _____
Place of Employment _____ Work Phone _____

MOTHER'S Name _____ Age _____
(circle one) Natural Adoptive Custodial
Education _____ Occupation _____
Place of Employment _____ Work Phone _____

**SIGNATURE:** _____ **DATE**: _____