Waxhaw NC 28173
P: 980-218-0515 F: 980-265-0015

General Information

Child's Name:___________________________________ Nickname:_______________________________

Date of Birth:___________________________________ Gender: ☐ Male ☐ Female

Address: ____ Home Phone:____________________________

____ Other Phone:____________________________

email:__________________________________

Parent/Guardian Name:_________________________________ Occupation/employer:_____________________

Parent/Guardian Name:__________________________________ Occupation/employer:_____________________

Emergency contact (name, relationship, phone#):____

Child's school and grade:____

Child's Physician (name and practice location):____

Medical Diagnosis if any:____

Reason for Referral:____

Referred By:____

Parents Primary Concern: ____

____

Background Information

Number of children in the family and ages:____

Has your child received previous evaluations and/or treatment (OT, PT, ST, psychological, etc): ☐ Yes ☐No

Type	Evaluation date	Clinic/professional's name	Date of Evaluation	Duration of treatment

Is your child currently receiving any medications?

Medication	Purpose	Frequency of dosage

Has your child had a vision test? ☐ Yes ☐ No Date:__________________ Findings:___________________

Has your child had a hearing test? ☐ Yes ☐ No Date:__________________ Findings:___________________

Is your child current on all immunizations/vaccinations? ☐ Yes ☐ No

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

Prenatal and Birth History

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:____

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

describe:____

Was the child full term? ☐ Yes ☐ No Number of weeks (gestational age):___________

Birth Weight:______________________________

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 so, how long?________________________________

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

☐ breathing difficulties ☐ incubation ☐ jaundice ☐ tube feedings ☐ forceps for delivery ☐ suction for delivery

☐ transfusion ☐ congenital defects ☐ other:_________________

Developmental and Medical History

Please provide ages as near as possible:

rolled over: ________ sat alone: ________ crawled: ________ walked:________ say words: ________

Is your child potty-trained? ☐ Yes ☐ No comments:____

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Does your child have regular sleep patterns? ☐ Yes ☐ No comments:___________________________________

Do you consider your child a 'picky eater'? ☐ Yes ☐ No comments:_____________________________________

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

☐ cried a lot, fussy, irritable	☐ drooled excessively	☐ high pain tolerance
☐ easy, generally compliant	☐ resisted being held	☐ sensitive to slight bumps/injuries
☐ alert	☐ difficulty with diaper changes	☐ difficulty with grooming (teeth, hair)
☐ quiet or passive	☐ very active	☐ frequent and/or intense meltdowns

Playground participation: ☐ avoids ☐ takes excessive risks ☐ typical participation

Enjoys birthday parties/play groups? ☐ Yes ☐ No

Seem fearful of heights? ☐ Yes ☐ No if so, please explain:____

Has your child had any of the following? *If yes, please describe and date.*

Childhood diseases or illnesses:____

Surgery:____

Serious injury:____

Casts or Braces:____

Ear infections ☐ Yes ☐ No how many and at what age(s)?____

Tubes in ears? ☐ Yes ☐ No

Allergies:____

Other:____

Insurance Information

Primary insurance company name:____

Insurance company phone number:_________________

Policy number:___________________________________ Group number:___________________________

Policy holder's name:_______________________________ Relationship to client:_____________________

Policy holder's DOB:________________________________ Employed by:____________________________________

Completed by:____ ***date:______________________***

Relationship to child:____