TRIANGLE
THERAPY SERVICES

Client History Form

Please fill out this form as completely as you can.
Your therapist may ask you additional questions to clarify or expand information.

Date: _____

I. Patient Information

Client's Name: _____Date of Birth____/_____/_____
Parent/Guardians Name:_____
Address:_____
Primary Phone Number: _____ Secondary Phone Number: _____
Physician: _____Reason for referral: _____
Diagnosis, if any: _____
Allergies: _____
Medical Precautions: _____
Dietary Restrictions: _____
Medications: _____
Who lives in the household with your child? _____
_____
Brief description of your home and routine:_____
_____
What are your main concerns with your child: _____
_____
What does your child find enjoyable?_____
What are your child's gifts? _____

II. Prenatal and Birth History

Child was born: full-term____ premature____ Weeks of pregnancy _____Birth weight _____
Delivery: vaginal _____ forceps _____ vacuum _____C-section____
Was your child placed in the Intensive Care Unit?_____ If so, how long? _____
Please describe any prenatal medical problems or complications at birth: _____
_____

III. Developmental Milestones – (mark approximate month)

Rolled over_____ Crawled_____ Sat alone_____ Crawled _____ Pulled to stand _____
Walked alone_____ Babbled_____ First word_____ Used spoon_____
Drank from a cup_____ Toilet trained_____
Comments _____
_____
_____

IV. Medical History (please include dates)

Hospitalizations: No _____ Yes_____ If yes, please describe _____

_____

Surgical Procedures: _____

Previous psychological evaluation: No ____ Yes_____ If yes, please describe_____

Equipment your child uses: Splints_____ Braces_____ Adaptive utensils_____ Walker_____ Wheelchair _____

Describe: _____

Please check all that apply to your child:

___Hearing aids ___Hearing difficulty ___Ear Tubes ___Chronic ear infections

___Vision difficulty ___Vision testing ___Glasses ___G-tube ___ Seizures _____

Please list any information regarding ear infections, enlarged tonsils or adenoids, mouth breathing

_____

Additional Comments: _____

V. School History/ Previous Therapy

School/Educational program currently attending and grade:_____

Special services received in school (include teacher/therapist if known):

OT _____ PT _____ Speech _____ Special Education _____ Behavior Intervention _____

Other special service ____ Please list:_____

Does your child's teacher have concerns with your child's development in any of the following areas?

Motor skills_____ Social abilities _____ Self-help skills_____ Learning abilities _____

School history including preschool and early intervention _____

_____

Previous Therapy _____

_____

Additional Comments: _____

VI. Sensory Processing

Please check any of the following that apply to your child:

___ Cries often	___ Grinds teeth	___ Sensitive to sound
___ Dislikes face/hair brushing	___ Seems to be "on the go"	___ Avoids touch from others
___ Clumsy	___ Poor attention span	___ Trouble with transitions
___ Dislikes tooth brushing	___ Weak muscles	___ Crave jumping/crash play
___ Anxious	___ Sensitive to light	___ Trouble attending to task
___ Rocks self	___ Picky eater	___ Dislikes playground
___ Mouths objects	___ Trouble with directions	___ Difficulty sleeping

VII. Social/Emotional Development

Does your child interact well with others ____Yes ____ No

Does your child have any trouble making friends? ____ Yes ____ No

Does your child have difficulty calming when upset ___Yes ____ No

Fears, Coping behaviors: _____

Additional comments: _____

VIII. Speech History

Does your child use eye contact with you/others? _____Does your child socially engage with you/others with smiles & nonverbal interaction? _____

Did your child babble and coo? _____ First words were before 18 months _____ or after 18 months _____

When did your child begin to combine words into simple phrases or sentences: _____

Please give examples of common word/sentences your child uses:_____

_____

If your child uses signs, please list the signs they know or use purposefully: _____

_____

What percentage of your child's speech do you understand? _____ Strangers?_____

Any concerns with stuttering? _____

Any history of cleft lip/palate or dental anomalies? _____

IX. Feeding History

Early feeding: bottle/breast/both (until what age) _____

Any difficulties with early feeding _____

Any problems with (describe below):

___Gagging ___Choking ___Reflux ___Excessive Drooling ____Food Stuffing ___Pocketing/holding ___

Puree foods ___Solid Foods ___Cup Drinking ___Straw Drinking ___Self-feeding ___Picky Eater ____Utensil Use

Please describe marked items:_____

Any nutritional concerns? _____

Food Preferences/Dislikes (Taste, Texture) _____

X. Self Care (please describe status in the following areas)

Toileting: _____

Grooming (Teeth, hair, bathing): _____

Undressing: _____

Dressing: _____

Buttons/Zippers: _____

Shoes/Socks: _____

Shoetying: _____

Describe any other self care challenges: _____

XI. Motor skills (please describe status in the following areas)

Ambulation status: _____

Gross motor (large muscle) challenges: _____

_____

Fine motor (small motor) challenges: _____

_____

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

_____ _____

Signature Date