Progress in Motion LLC
Waxhaw NC 28173
980-218-0515

General Information

Child's Name:_____ Nickname:_____

Date of Birth:_____ Gender: ☐ Male ☐ Female

Address: _____ Home Phone:_____

_____ Other Phone:_____

email:_____

Mother's Name:_____ Occupation/employer:_____

Father's 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:_____

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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

Mother's age at birth of child:_____ Fathers 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:_____

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:_____