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)

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): Bottle Sippy Cup Regular Cup Straw Other	Does the patient eat jar foods? Y/N Any issues transitioning to jar food? Y/N Stage I Stage II Stage III Graduates Table Foods
Does the patient drool excessively? Y/N	Does the patient have preferred temperatures/textures? Y/N 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**: _____