Therapy
Solutions
For
Children
Inc.

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HISTORY INFORMATION

Child's Name: ____________________________ Date of Birth: _________________________
Current School or Program: ____
Teacher's Name: __________________________ Phone #: _____________________________

Please describe your concerns and primary reasons for seeking eval/treatment: _________________________
____
____
____

Briefly describe medical history (or attach reports that will summarize information): _____________________
____
____

Allergies (Mild/Severe): ____
____

Describe current health status: ____
____
____

Please briefly describe development and therapeutic history: ____
____
____

Pregnancy and Birth History:
1. Length of pregnancy: __________________
2. Describe any complications during pregnancy: ____
____
3. Did mother have any infections or illnesses during pregnancy? _____________________________________
____
4. Did mother's water break more than 24 hours prior to delivery? ____________________________________
5. Did mother develop toxemia/ high blood pressure? When? ____
6. Did mother have any shocks or unusual stress during pregnancy? ____________________________________
____
7. Were there any complications during labor or delivery? ____
____
8.Were any drugs used during labor? ____

9.Were there any problems at birth? (breech, c-section, others) ____

____

____

10. Birth weight: ______________ Weight at discharge: ___________________

11. Did baby require any blood transfusions, oxygen, or time in NICU? ____________________________

____

12. Did your child have any of the following:

Prematurity _________

Respiratory problems ________

Need a respirator _______ How long? ___________

Small for Gestational age ___________

Heart Defect __________

Jaundice __________

How long under lights? _____________________

Seizures _________

Infections ____________________________

Feeding problems as a newborn ____

Surgery as a newborn ____

Congenital Abnormalities ____

13. At what age did the following occur?

a. Turn head from side to side while on stomach ___________________________

b. Roll over __________________

c. Sit alone unsupported ____________________

d. Crawl ___________________

e. Stand alone __________________

f. Walk independently ___________________

g. Run __________________

h. Show hand preference _______________

Please provide any additional information about your child that we may need to know.

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