Children's Therapy

UW Medicine
VALLEY
MEDICAL CENTER

# CHILDREN'S THERAPY DEVELOPMENTAL HISTORY

Please fill out this form as completely as possible and bring it with you to your appointment. For those areas that are not applicable to your child, please mark them with N/A (not applicable).

Date: ______________________

Person completing form: ______________________ Relationship: ☐ Parent ☐ Guardian ☐ Interpreter ☐ Other

## I. IDENTIFICATION/NATIVE LANGUAGE(S)/REASON FOR REFERRAL TO CHILDREN'S THERAPY

Child's Name: ______________________ Date of Birth: ______________

Language(s) spoken in the home: ______________________

Specific concerns: ______________________

When were you first concerned? ______________________

What would you like to learn from this evaluation? ______________________

## II. MEDICAL

Mother's health during pregnancy: ☐ Poor ☐ Fair ☐ Good ☐ Excellent Comments: ______________

Length of pregnancy: ________ Delivery: ☐ Breech ☐ C-Section ☐ Vaginal Comments: ______________

Please check any of the following that your child has experienced:

| | | | |
|---|---|---|---|
| ☐ | heart complication(s) | ☐ | torticollis/plagiocephaly/scoliosis |
| ☐ | serious illness/accident: ______________ | ☐ | pneumonia/asthma/apnea |
| ☐ | hospitalization/surgery/operation: | ☐ | allergies (if so, to what): ______________ |
| ☐ | ear/sinus infections | ☐ | difficulty gaining weight/height |
| ☐ | reflux/vomiting/nausea | ☐ | difficulty controlling bladder/bowel movements |
| ☐ | seizures/staring spells | ☐ | delayed developmental milestones (motor/speech/feeding) |

Child's current medication(s), dosage, reason for taking: ______________________

Medical/educational diagnoses: ______________________

Please check which of the following specialists your child has seen or is currently seeing:

| | | | |
|---|---|---|---|
| ☐ | Cardiologist/Neurologist | ☐ | Orthopedist/Podiatrist/Chiropractor |
| ☐ | Audiologist/ Ear, Nose, Throat Specialist (ENT) | ☐ | Ophthalmologist/Optometrist |
| ☐ | Psychologist/Psychiatrist | ☐ | SLP ☐ PT ☐ OT ☐ Behaviorist |
| ☐ | Gastroenterologist/Nutritionist | ☐ | other(s): |

Please list any ☐ speech ☐ physical ☐ hearing ☐ learning problems among family members: ______________

______________________

Has your child attended therapy before? ☐ Yes ☐ No How was the progress? ☐ Slow ☐ Fast

## III. ACADEMIC HISTORY AND COMMUNITY ACTIVITIES

Child's School District: ______________ School Name: ______________ Grade: ________

Special education or special assistance needed (☐ IEP ☐ 504 Plan)? If so, please bring a copy to the appointment.

Community, physical, and recreational activities that your family or child is involved in______________

______________________

Patient Label