Pre-School Age History Form

Today's Date: ___________________________________

Child's Name: ____ Date of Birth: ___________________________________

Parents' / Legal Guardians' Names: ____
Home Address: ____ Home Phone: (_____)_____________________
____ Cell Phone: (_____)_____________________
County: ____ Work Phone:(_____)_____________________
Email Address: ____
Physical address listed above is for mom / dad / caregiver ____
Can we contact you via text / e-mail regarding your child's therapy schedule and follow-up with therapy appointments?
Yes No

Diagnosis(es):____
____

Medical Insurance Company:____
Policy Number:____
Who will be responsible for payments:____
Emergency contact information:
Name:____ Relationship:_____________________________________
Phone Number:____

Child's Pediatrician:____
Address:____
Zip Code:_____________ Phone:_________________________ Fax:____
How long has your child been under this physician's care?:____

Concerns for child/reason for evaluation:
____ Language: The number of words he/she uses to communicate
____ Speech: The sounds your child uses in speech
____ Feeding/Swallowing/Oral Motor: Child is not eating enough foods, is a picky eater, doesn't like certain textures of foods, is a messy eater, has trouble swallowing foods, has oral ties, may not move mouth appropriately when eating.

What do you hope to gain from today's evaluation? ____
____
____
____

When did you first notice this problem(s)? ____

Therapist's Notes:____
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Pregnancy, Labor, and Delivery:

1. List any problems or complications during pregnancy (i.e.: gestational diabetes, eclampsia, maternal seizures, accidents/injuries, etc.):
   ____
   ____

2. List all medications/drugs taken during pregnancy (i.e.: prenatal vitamins, medications for high blood pressure, medications for seizures, cocaine, heroin, etc.):
   ____
   ____

3. List any problems or complications during labor and/or delivery (i.e.: cord wrapped around neck, breech delivery, anoxia/"blue" at birth, respiratory distress, induced birth, limpness, stiffness, etc.):
   ____
   ____

4. Pregnancy: ___ Full Term ___Premature
   Length of Gestation:_________________
   Length of total labor:________________________________ Difficult labor: __ Yes __No
   Delivery Type: __Vaginal __C-section If C-section, what type: __ Emergency __ Planned
   Child's birth weight: _____lbs. _____oz.
   Elaborate on above delivery complications:____
   ____
   ____
   ____
   Length of hospitalization for child:____________________
   Complications at birth:
   __Jaundice __Cyanosis __Congenital defects __Breathing Difficulties
   Other:____

   Was there a need for:
   __Oxygen __Transfusions __Tube Feedings
   If so, please explain:____
   ____

   Were there any feeding difficulties in infancy: __Yes __No
   Explain:____
   ____

5. List any problems or complications your child had after birth, as well as any medical conditions/illnesses your child was/has been diagnosed with (e.g.: poor feeder, respiratory distress, seizures, etc.):
   ____
   ____
   ____
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Therapist's Notes:____
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Developmental and Medical History:

1. How old was your child when he/she:

Sat alone: ___________________ Stood: ______________________ Crawled: _______________________
Walked alone: ________________ Dressed self: ________________ Toileted:_________________________
Babbled: ____________________ Used first words: ______________ Combined words: ________________
Used sentences: ______________ Fed self:_____________________

2. Currently, what is your child's main way he/she communicates?
____Crying/Whining _____2 & 3 word phrases ____ Making noises
____Complete sentences _____Gesturing/Pointing ____Single words
If less than 10 words, please list____

3. Language(s) spoken in the home: ____
Does your child speak this language? YES NO
Does your child understand this language? YES NO
Does your child speak English? YES NO
Does your child understand English? YES NO

4. Is your child easily understood by:
You? YES NO **Other family members?** YES NO **People outside the home?** YES NO

5. Check all below that your child has a history of:
___ High fevers ___ Ear infections ___ Seizures ___ Mouth breathing ____Frequent colds
___ Hoarseness ___Acid Reflux ___ Swallowing problems ___ Feeding problems
___ Constipation/Diarrhea
___ Allergies: __None __Seasonal __Food __Other
Please list all allergies, including foods:____
____
Other:____

3. Child's general health at present: __Good __Fair __Poor

4. List any accidents / injuries / surgeries / major illnesses / diseases your child has incurred and their dates:
____________________________________ __________
____________________________________ __________
____________________________________ __________
____________________________________ __________

5. List all medications your child currently takes:

Medication	Dose (i.e.: mg)	Frequency	Reason
__________________	___________	____________	_________________________________
__________________	___________	____________	_________________________________
__________________	___________	____________	_________________________________
__________________	___________	____________	_________________________________

6. Has your child ever had his/hearing tested? YES NO
If YES:
Date:_______________________________
Results____
Does your child have problems with his/her hearing? If YES, please explain:
____

7. Has your child ever had his/her vision tested? YES NO
If YES:
Date:_______________________________
Results____
Does your child have problems with his/her hearing? If YES, please explain:

8. Has your child had any previous testing?

			DATE:	RESULTS:
MRI	NO	YES	_________	_______________________________
CT	NO	YES	_________	_______________________________
EEG	NO	YES	_________	_______________________________
Developmental/Educational	NO	YES	_________	_______________________________
Psychological/Psychiatric	NO	YES	_________	_______________________________
Neurological	NO	YES	_________	_______________________________

9. Has your child achieved skills and then lost them: __Yes __No
Explain (what and when):____
____
____

10. Does your child attend daycare or preschool? NO YES, __________ hours weekly
Setting:
___ In-home daycare: How many children attend? ____ How many children his/her age? ____
___ Private daycare center: How many children in his/her “group?” ____
Name of the center: ____
___ Pre-K through the public school system or private school: How many children are in the class? ____
Name of the center: ____
___ Headstart: How many children are in the class? ____
Name of the center: ____

11. With whom does your child spend his/her days? ____

12. What does your child do during the day? ____

13. List all special education/therapy services your child is **CURRENTLY** receiving (i.e.: speech/language therapy, OT, PT, early intervention, etc.):

Service	Provided by(ie: school/private)	Frequency(ie: 2 x week)	Duration(since age 4)
____________	______________	____________	_____________
____________	______________	____________	_____________
____________	______________	____________	_____________

14. List all other special education/therapy services your child has **RECEIVED IN THE PAST**, but is no longer receiving (i.e.: speech/language therapy, OT, PT, early intervention, etc.):

Service	Provided by(ie: school/private)	Frequency(ie: 2 x week)	Duration(since age 4)
____________	______________	____________	_____________
____________	______________	____________	_____________
____________	______________	____________	_____________

15. Has your child made progress in previous speech, language, and/or feeding therapy? YES NO
Please explain: ____
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Therapist’s Notes:____
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General Statements and Questions Regarding Your Child (please check all that apply):

1. During playtime my child:
   ________ Does not seem very interested in toys.
   ________ Explores toys.
   ________ Typically plays with other children.
   ________ Tends to play by him/herself.
   ________ Shares toys.
   ________ Takes turns.
   ________ What is his/her favorite toy or activity?____
   ________ Other:____

2. During the nighttime my child:
   ________ Sleeps well throughout the entire night.
   ________ Wakes up once in a while, but easily goes back to sleep.
   ________ Tends to wake up 1-3 times per night, and requires attention.
   ________ Sleeps some, but requires some sort of food/drink during the night.
   ________ Sleeps some, but typically plays in the middle of the night.
   ________ Snores when sleeping.
   ________ Is an open mouth breather when sleeping.
   ________ Other:____

3. Regarding potty training my child is:
   ________ Fully trained.
   ________ Says when he/she needs to use the bathroom, but not fully trained.
   ________ Indicates when his/her diaper is wet or dirty, but not fully trained.
   ________ Seems interested in potty training, but not fully trained.
   ________ Shows no interest in potty training.
   ________ Other:____

4. Regarding my child's attention:
   ________ He/She seems to attend to me and most activities 80-100% of the time.
   ________ He/She seems to attend to me and most activities 50-75% of the time.
   ________ He/She doesn't attend to me but stays focused during other activities.
   ________ He/She has difficulty attending at all times.
   ________ His/Her average attending time to books and toys is_____________________________________
   ________ Other:____

5. Regarding my child's memory:
   ________ He/She tends to remember 2-3 step directions.
   ________ He/She tends to remember only one step directions.
   ________ He/She does not follow through with any directions.
   ________ He/She tends to ask for directions to be repeated.
   ________ Other:____

Therapist's Notes:____
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Oral Mechanism and Feeding:

1. Does your child have a history of tethered oral tissues? YES NO
   If YES:
   In what oral structures were restrictions present? (Circle all that apply)
   Upper lip Lower lip Cheek area
   Anterior tongue Posterior Tongue

   Has your child had remediation surgery for this? YES NO
   Date of surgery: ______________________________
   Surgery completed by: ______________________________
   Date of Follow-up:______________________________
   Did your doctor give you post-surgery stretches? YES NO

2. Does your child have tightness on one side or torticollis?

3. Has your child been diagnosed with plagiocephaly? YES NO
   If YES, is your child receiving any intervention in this regard? Please explain: ______________________________
   ____

4. Does your child have a history of: (Circle all that apply)
   Drooling Mouth breathing loss of liquid or food when eating/drinking

5. Does your child have a history of or currently do any of the following (check all that apply):
   _______ Thumb/finger sucking At what age__________ Until what age____________
   _______ Using pacifier At what age__________ Until what age____________
   _______ Putting objects in mouth At what age__________ Until what age____________

6. Teeth brushing:
   a. Does your child brush his/her teeth independently or need your help?______________________________
   b. If you help them, do they enjoy having their teeth brushed?______________________________
   c. Do they bite down or chew on the toothbrush?______________________________
   d. Are they seen by a dentist? If yes, who?______________________________
   e. Have they had dental issues? If yes, please explain:
   ____

7. Does/Did your child have trouble with any of the following? YES NO
   Breast-feeding Bottle-feeding Baby foods Table foods
   If yes, please explain: ______________________________

8. Would you consider your child to be a picky eater? YES NO
   If yes, please explain: ______________________________

9. Is your child a messy eater? YES NO
   If yes, please explain: ______________________________

10. Can your child drink from a variety of containers (open cup, straw, sippy, water bottle, etc)? YES NO
    If your child has difficulties with one of these, please list:______________________________

Therapist's Notes:______________________________
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Family Information and History:

1. Past family history of: (please check) Who?
   - ___Late talking ____________________
   - ___Speech/fluency problems ____________________
   - ___Language problems ____________________
   - ___Cognitive impairment ____________________
   - ___Learning disabilities ____________________
   - ___Dyslexia ____________________
   - ___Psychological/psychiatric problems ____________________
   - ___Neurological problems ____________________
   - ___Autism ____________________
   - ___Genetic disorders ____________________
   - ___Hearing problems ____________________
   - ___Other ____________________

2. Does anyone in your family have a history of food allergies/sensitivities? YES NO
   If yes, please list:____________________
   ____

3. List all people living in the home:

Name	Age	Relationship

4. Circle parents' level of education:

Mother:	Grade school	High school	College	5+
Father:	Grade school	High school	College	5+

5. Mother's current occupation/job: ____________________
6. Father's current occupation/job: ____________________

Other:

Please list any other information you feel is important for us to know:

____

Therapist's Notes:____________________

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<u>**General Consent Form:**</u>

TheraKids, Inc. may need to contact, or be contacted by, other professionals who have seen or currently see/work with your child. The need for contact may occur due to these needs:

1. Obtaining previous medical or other professional records necessary for evaluation and/or therapy.
2. Discussing your child's evaluation and /or therapy in order to address concerns, recommend additional services, referral to other professionals, and/or to discuss the child's progress.
3. Releasing copies of the evaluation report or progress notes, including documentation to insurance companies.

I hereby consent to the release of all therapeutic records (including evaluations, daily progress notes, or other documents) to the following:

Child's Name:________________________________ Child's Date of Birth:____________________________
Your Name (print):____________________________ Relation to Child:_________________________________
Your Signature:_______________________________ Date:____
Are you the legal guardian for this child? □ Yes □No If no, name of legal guardian:____________________________

(Please check each box that applies and print clearly)

□ Pediatrician Name:____________________________ Group Name:__________________________________
Phone:______________________________ Fax:_______________________________________
Address:____

□ Other Doctor Name:____________________________ Specialty:____________________________________
Phone:______________________________ Fax:_______________________________________
Address:____
Name of Facility:____

□ Other Doctor Name:____________________________ Specialty:____________________________________
Phone:______________________________ Fax:_______________________________________
Address:____
Name of Facility:____

□ Therapy Name:______________________________ Specialty:_______________________________
Phone:______________________________ Email:____________________________________
Name of Facility:____

□ Therapy Name:______________________________ Specialty:_______________________________
Phone:______________________________ Email:____________________________________
Name of Facility:____

□ Therapy Name:______________________________ Specialty:_______________________________
Phone:______________________________ Email:____________________________________
Name of Facility:____

□ School Name of School:_____________________ Teacher/Therapist Name:__________________
Phone:______________________________ Fax:_______________________________________
Address:____

□ Family Members Name:______________________________ Relation to Child:_________________________
Phone:______________________________ Email:____________________________________
Address:____

Name:______________________________ Relation to Child:_________________________
Phone:______________________________ Email:____________________________________
Address:____

Appointment and Daily Schedule Form

Child's Name:____ Date of Birth____________________
Your Name:____ Relation to Child:________________

Today your child is being assessed to determine/rule-out his/her need for therapy. If your child does qualify for therapy, we will need to arrange days and times with you that would be optimal for your child to attend therapy. Although it is not always possible for us to meet these exact days and times, we do try our best to accommodate your preferences.

Below, please list **ALL** days and hours (Monday-Friday) that your child is available. Please make sure to fill this out accurately taking into account any time your child may be in school or other therapies, may have special activities, and may continue to have the need for naps.

Day:__________________________ Times Available:____
Day:__________________________ Times Available:____
Day:__________________________ Times Available:____
Day:__________________________ Times Available:____
Day:__________________________ Times Available:____

HIPAA – Notice of Privacy Practices

Along with this history form you were given a sheet with information regarding out privacy practices. Please fill out and sign below as confirmation that you were given this information.

I, (print name)____, have received and read the following documents, and they were explained to me, as needed: ***Notice of Privacy Practices, as required by HIPAA; Letter of introduction to TheraKids, Inc.***

____ ______________________________
Signature/Relation to patient **Date**

THANK YOU FOR YOUR CAREFUL ATTENTION TO THIS FORM.
This confidential information will be used to assist us in the evaluation of your child.