KID O'THERAPY, LLC
Play With Purpose
Physical Therapy, Speech Therapy, &
Occupational Therapy for Children

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www.kidotherapy.com

Child's Name: _____ Child's Legal Name: _____

Date of Birth: _____ Age: ____ Sex: _____ SS#: _____

Child's Legal Address: _____

Child's Mailing Address: _____

Phone Number: _____

Form Completed by: _____ Date Completed: _____

Parent/Guardian's Name: _____

Address: _____

_____

Place of Employment: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Relationship to Child: _____

Parent/Guardian's Name: _____

Address: _____

_____

Place of Employment: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Relationship to Child: _____

Please state current custody arrangements (i.e. sole, joint): _____

_____

Family/Persons living in the home:

Name	Relationship to child	Sex	Age

Family History:

	Allergies		Vision problems		Alcoholism
	Clumsiness		Birth defects		Intellectual Disabilities
	Learning Disability		Hearing Loss		Cerebral Palsy
	Sleep Disorders		Arthritis		Autism
	Drug Abuse		Sexual Abuse		Joint Problems

Please explain diagnosis and relationship to your child:

_____

_____

_____

_____

Previous School Experience:

Type of School	School Name	Hours/Days/Week	Dates Attended

How does/did your child feel about these experiences?

_____

_____

CHILD'S MEDICAL HISTORY:

Primary Care Physician: _____ Physician Phone: _____

Physician's address: _____

Other Specialists/Physicians/Therapists:

Name	Area of Specialty	Duration/Frequency

Has your child had any of the following evaluations/assessments?

	Date of Most Recent:	Results:
Hearing		
Vision		
Occupational Therapy		
Physical Therapy		
Speech and Language		
Developmental		
Neurological		
Physiological		

Current Medical Diagnoses:

	Anxiety		Apraxia		Asperger's
	Asthma		Attention Deficit Disorder		Attention Deficit Disorder with Hyperactivity
	Autism		Brain Injury		Cerebral Palsy
	Deafness		Depression		Diabetes
	Down Syndrome		Fine Motor Delays		Gross Motor Delays
	Hearing Loss		Juvenile Rheumatoid Arthritis		Intellectual Disabilities
	Pervasive Developmental Disorder-NOS		Post-Traumatic Stress Disorder		Seizures
	Sensory Integration Dys		Visually Impaired		Other(s), please list below

Other (Please List): _____

_____

_____

Allergies/Dietary Needs: _____

_____

_____

Current Medications/Supplements: (List name of medication and reason for medication)

_____

_____

_____

_____

Previous Hospitalizations:

Injury/Illness	Date(s)

Is your child currently receiving services? ____ If yes, what type of services, who is providing services, and how often?

_____

_____

Do you notice any of the following?

	Allergies		Headaches		Eating Problems
	Frequent high Fevers		Sleeping Problems		Fatigue
	Mouth Breathing/Snoring				

Do you have any concerns about your child's vision? _____

Does your child wear glasses? _____

If yes, are the glasses for reading or distance and some or all of the time: _____

How many ear infections has your child had? _____

Were tubes ever inserted? _____ If so, when? _____

Does your child ever seem to have difficulty hearing? _____

Does your child have any difficulty with chewing, swallowing, eating? _____

If yes, please explain: _____

_____

DEVELOPMENTAL HISTORY:

Complications or problems during pregnancy or at birth: _____

_____

Length of pregnancy: _____ Birth Weight: _____

Medications/drugs used during pregnancy: _____

_____

Alcohol consumption during pregnancy? _____ If so, how often? _____

Milestones:

Rollover	
Sit independently	
Crawl	
Pull to stand	
Stand alone	
Walk	
Walk up stairs	
Walk down stairs	
Toilet independently	
Finger feed self	

Drink from a cup	
Use a fork	
Use a spoon	
Dress independently	
Ride a bike	
Tie shoes	
Pick up small objects	
Develop a dominant hand	Which one: L / R

Approximately, at what age did your child begin to:

Use words: _____ put 2-3 words together: _____

Make sentences: _____ put sentences together: _____

Did your child start to talk and then stop for a period of time? _____ If so, please describe: _____

_____

If your child does not talk, does your child:

Make sounds to indicate what he/she needs? _____

Imitate the sounds of others? _____

Use gestures to indicate wants/needs? _____

Use sign language? _____

Use an adaptive communication device? _____

Does your child have a problem:

Understanding directions/questions? _____ Making sounds correctly? _____

Talking too fast? _____ With the way his/her voice sounds? _____

Making sentences? _____ Stuttering? _____

Has there been any change in your child's speech in the last six months? _____

Can most adults understand your child? _____ Can most children understand your child? _____

Does your child become frustrated trying to talk? _____

Has anyone told you he/she is concerned about your child's speck and language? _____

Are you concerned with your child's speech and language? _____

Is there another language spoken in the home? _____ If so, what language? _____

BEHAVIORAL HISTORY:

Does your child:	Often	Sometimes	Never
Generally follow verbal directions			
Seem to be restless or fidgety			
Have temper tantrums; please describe actions/duration:			
Is your child impulsive			
Get upset easily			
Tire easily			
Pinch, bit, or hurt oneself			
Have a difficult time with change/transitions; please explain:			
Is your child easily distracted			
Does your child understand personal safety			
Lines up objects in a row			
Repeats movements over and over			
Tends to be angry and/or physically aggressive? Please explain:			

Describe your child: (circle all that apply)

Friendly_____ Shy _____ Cooperative _____ Independent _____

Stubborn _____ Difficult to handle _____ Other: _____

Is your child: Very active _____ Active _____ Quiet _____

Please describe: _____

_____

Does your child:

Get angry easily _____ Get upset easily _____ Get extremely quiet _____

Seem easy going and unruffled _____ Appear independent and likes own way _____

Is your child fearful of new situations or strangers? _____

Can your child be left with caregivers? _____

PLAY BEHAVIORS:

When your child plays, does he/she prefer:

Several others _____ One to two others _____ Mainly siblings/relatives _____ Alone _____

Which activities does your child prefer:

Outdoor _____ Indoor _____ Likes both equally _____ Sedentary _____ Active _____

Please list your child's favorite activities: _____

_____

_____

When your child plays alone does he/she: ___ Need someone present much to intervene ___ Spend time in any one activity ___ Need a lot of things to keep occupied ___ Occupy self by finding/doing own activity	Does your child like to be read to: ___ Likes it a lot ___ Just started to like this ___ Doesn't like it

FAMILY CONCERNS:

What are your concerns about your child? _____

_____

_____

_____

What changes in your child's behavior and development would you like to see? _____

_____

_____

_____