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| **GENERAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | |
| Name:Click here to enter text. | | | | | | | | | | | | | | | DOB:Click here to enter text. | | | | Date:Click here to enter text. | | | | | |
| Siblings Names and Ages:Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Living Situation – Any recent changes:Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Is your child adopted or in foster care with you? Describe previous home experiences:  Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| When did you first become concerned about your child’s development? What are your concerns for him/her?  Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| What do you see as your child’s strengths?  Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| At what age did your child achieve these milestones? | | | | | | | | | | | | | | | | | | | | | | | | |
| Sitting Alone | | | Click here to enter text. | | | | Crawling | | | | | | | Click here to enter text. | | | | Walking | | | | | Click here to enter text. | |
| Babble | | | Click here to enter text. | | | | First Word | | | | | | | Click here to enter text. | | | | Combined Words | | | | | Click here to enter text. | |
| Drink from a cup | | | Click here to enter text. | | | | Chew Solid Food | | | | | | | Click here to enter text. | | | | Spoke in sentences | | | | | Click here to enter text. | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe if mother had any illnesses or complications during pregnancy or delivery?  Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Birth Weight: | | Click here to enter text. | | | Length: | | | Click here to enter text. | | | | | Number of weeks of birth gestation: | | | | | | | | Click here to enter text. | | | |
| Vision – Tested? | | | ☐Yes ☐No | | | | Results: | | | | Click here to enter text. | | | | | | Corrective Lenses? | | | | | | ☐Yes ☐No | |
| Hearing – Tested? | | | ☐Yes ☐No | | | | Results: | | | | Click here to enter text. | | | | | | Ear Infections? | | | | | | ☐Yes ☐No | |
| Feeding – Describe if your child had any feeding problems as an infant:  Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Breastfed? | ☐Yes ☐No | | | How long? | | | | | Click here to enter text. | | | | | Bottle fed? | | ☐Yes ☐No | | | | How long? | | | | Click here to enter text. |
| Describe if your child had colic or reflux as an infant: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical conditions/surgery:  Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication(include vitamins, prescriptions, OTC or homeopathic med):  Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Food Intolerances: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| **CHILD INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please describe your child’s personality: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| How do you discipline issues at home? Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Does your child have tantrums? ☐Yes ☐ No | | | | | | | | | | If “YES” – How often? Click here to enter text. | | | | | | | | | | | | | | |
| Describe how your child handles changes to routine: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe your child’s eating habits: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe your child’s sleeping habits/patterns: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe your child’s toilet training history: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe your child’s ability for dressing, bathing and grooming: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Language(s) spoken in the home: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| How does your child make wants known? Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Which sounds do you notice being correctly produced? Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| How many words does your child use? Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| How long are your child’s sentences? Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Does your child have any difficulty understanding you? (Describe): Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Does your child have any difficulty following directions? (Describe): Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| Are there are speech or hearing problems in the immediate or extended family? (Explain): Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| How well is your child understood by: (i.e. what percentage of the time) | | | | | | | | | | | | | | | | | | | | | | | | |
| Mom | | Click here to enter text. | | | | Dad | | | | | | Click here to enter text. | | | | | Younger siblings | | | | | Click here to enter text. | | |
| Older siblings | | Click here to enter text. | | | | Extended family | | | | | | Click here to enter text. | | | | | Unfamiliar adults | | | | | Click here to enter text. | | |
| Describe what it is like to have a conversation with your child: Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |
| What are your goals for therapy intervention for your child? Click here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | |