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Therapy Evaluation

Child's Name: ______________________ __Birth Date: _____________

Parent's Name(s): ____

Phone Number: _____________________ Cell Phone: _______________

Doctor's name__________________________

Diagnosis if any: _________________________

Concerns: ____
____
____
____
____
____

School: ________________________ Grade:_______________________

Please answer the following questions to the best of your ability and make comments as appropriate.

Medical History Prior to Birth:	YES	NO	COMMENTS
Were there any illnesses, injuries, bleeding, operations, or any difficulties?			
Was the pregnancy full-term? If not, please give weeks and weight.			
Medical History:			
Was the delivery (vaginal, breech, caesarian, other)? Please specify.			
What was the approx. length of labor?			
Were forceps or suctioning used?			
What was the child's birth weight?			
Were there any complications			

following birth including needing oxygen or additional respiratory assistance, transfusions, tube feedings, etc?			
Was the length of the infant's stay in the hospital unusually long? If so, why?			
Were there any feeding difficulties after birth including problems sucking or nutrient intake? Please specify.			
Was the child bottle-fed?			
Has your child had any significant childhood illnesses? If so, please be specific.			
Has your child had any significant physical injuries? If so, please be specific.			
Has your child been seen for any physical medical problems?			
Does your child experience frequent ear infections?			
Does your child have P.E. tubes? If so, in what ears.			
Does your child have any allergies, food or environmental? Please specify.			
Does your child have a vision problem? If yes, please specify.			
Does your child have a hearing problem?			
Is your child currently on any medications? If yes, please list and state reason.			
Has your child had toxicity testing? If so, what were the results?			
Does your child use any adaptive equipment? Please specify.			
Do you have any home therapy equipment (i.e. Trampoline, swing, etc.)? Please specify.			
Does your child have any dietary restrictions? If so, please explain.			
Developmental History:			
At what age did your child: (please specify ages as near as possible)			

a. roll over from stomach to back?	
roll over from back to stomach?	
sit independently?	
crawl?	
cruise around furniture?	
walk?	
speak his/her first word? What was it?	
speak combined words?	
speak his/her first sentence?	
drink from a cup independently?	
use a spoon independently?	
feed self independently?	
dress self independently?	
Family History:	
Do any of your child's siblings receive therapy services or have a related diagnosis?	
Is there a family history of any other related medical (physical or emotional) conditions? If so, what is their relation to the child?	
Goal Areas:	
In the next several months, I would like my child to be able to: In the area of occupational, physical, or speech, therapy?	
Additional Questions:	
What does your child like to do?	
What does your child dislike?	
Has your child received any therapy services in the past? If so, please specify where and when.	