

 6300 22 Mile Road, Suite 5, Shelby TWP, MI 48317

Telephone: (586)330-0872

Patient History

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: □ Female □ Male

Date/Purpose of last medical checkup: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who was this medical checkup with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medical precautions the therapist should be aware of when working with your child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Physician and Health Care Provider Information**

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| Please check **ALL** of the following who your child has seen in the past, is currently seeing, or will be seeing in the future: |
| □ Pediatrician(s) □ Ear, Nose, and Throat (ENT) □ Neurologist □ Orthopedic Specialist □ Psych/Counsellor □ ABA □ Dietician □ Care Coordinator □ Dentist□ OT □ PT □ SLP □ Opthamologist/Optometrist □ Vision Therapist □ Other: \_\_\_\_\_\_\_ |

Please list **ALL** physicians and health care providers that your child has seen, including future appointments and practitioners your child will be seeing:

|  |  |
| --- | --- |
| Name: | Profession/Specialty: |
| Address/Location: | Phone: |

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| Name: | Profession/Specialty: |
| Address/Location: | Phone: |

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| Name: | Profession/Specialty: |
| Address/Location: | Phone: |

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| Name: | Profession/Specialty: |
| Address/Location: | Phone: |

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| --- | --- |
| Name: | Profession/Specialty: |
| Address/Location: | Phone: |

**Previous Testing and Treatments**

Please provide information about any previous **assessments or treatment**

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| --- | --- | --- |
|  | Assessments | Treatment |
|  | Yes | No | Place/Date | Yes | No | Place/Date |
| Medical |  |  |  |  |  |  |
| Audiological |  |  |  |  |  |  |
| Speech |  |  |  |  |  |  |
| Educational |  |  |  |  |  |  |
| Psychological |  |  |  |  |  |  |
| Occupational Therapy |  |  |  |  |  |  |
| Physical Therapy |  |  |  |  |  |  |

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| Which of the following has your child been **diagnosed** with (Please check all that apply): |
| √ | Diagnosis | Who Made the Diagnosis |
|  | ADD |  |
|  | ADHD |  |
|  | Anxiety DisorderSpecify: |  |
|  | Autism Spectrum Disorder |  |
|  | Cerebral Palsy (CP) |  |
|  | Cognitive Delay |  |
|  | Down Syndrome |  |
|  | Dyslexia |  |
|  | Emotional DisorderSpecify: |  |
|  | Failure To Thrive (FTT) |  |
|  | Fragile X Syndrome |  |
|  | Genetic Disorder or Syndrome Specify: |  |
|  | Learning DisabilitiesSpecify: |  |
|  | Mood DisorderSpecify: |  |
|  | Oppositional Defiance Disorder (ODD) |  |
|  | Post Traumatic Stress Disorder (PTSD) |  |
|  | Sensory Processing Disorder (SPD) or Sensory Integration Dysfunction |  |
|  | Tourette’s Syndrome |  |
|  | Traumatic Brain Injury (TBI) |  |
|  | OtherSpecify: |  |

**Medical Information**

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| --- | --- | --- | --- |
| √ | Illness/Problem | Age | Frequency/Other Details |
|  | Ear Infections |  |  |
|  | Tubes in Ears |  |  |
|  | Respiratory Problems |  |  |
|  | Cardiac/Heart Problems |  |  |
|  | High Fever |  |  |
|  | Meningitis |  |  |
|  | Adenoid/Tonsil Problems |  |  |
|  | Frequent Colds |  |  |
|  | Strep Throat |  |  |
|  | Food Allergies |  |  |
|  | Environmental Allergies |  |  |
|  | Asthma |  |  |
|  | Bronchitis |  |  |
|  | Skin problems |  |  |
|  | Gastro-Intestinal problems |  |  |
|  | Reflux |  |  |
|  | Seizures |  |  |
|  | Epilepsy |  |  |
|  | Nightmares |  |  |
|  | Sleep Problems |  |  |
|  | Broken Limbs |  |  |
|  | Surgeries |  |  |
|  | Hospitalizations |  |  |
|  | Other |  |  |

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| Has your child ever had an accident/injury requiring medical attention? □ Yes □ No |
| If Yes, Please explain: |
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| --- |
| Are there any other medical illnesses or conditions which have been diagnosed? □ Yes □ No |
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| Is your child in good general health at the present time?  |
|  |

**Medications**

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| Please list all medications that your child has received **IN THE PAST**: |
| Medication | Purpose | When Taken |
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| Please list all medications that your child is **CURRENTLY** taking: |
| Medication | Dosage | Purpose |
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**Pregnancy, Labor and Delivery**

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| Describe your experience during pregnancy, labor and delivery: |
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| Please provide the following details about the **labor and delivery** |
| Length of Labor | hours | Comments: |
| Gestation age at birth | weeks |  |
| Birth Weight | Lbs. Ounces |  |
| APGAR ratings (if known) |  |  |
|  | Yes | No | Comments |
| Was your child premature? |  |  | How early? |
| Were forceps used to assist with delivery? |  |  |  |
| Was suction used to assist with delivery? |  |  |  |
| Was this a vaginal delivery? |  |  |  |
| Was this a c-section delivery? |  |  |  |
| Was your child in a head-down position? |  |  |  |
| Was your child in a breech position? |  |  |  |
| Did your child cry immediately after birth? |  |  |  |
| Did your child require special treatment? |  |  |  |
|  Oxygen? |  |  |  |
|  Jaundice? |  |  |  |
|  NICU? |  |  |  |
|  Procedures? |  |  |  |
|  Feeding Issues? |  |  |  |
| Did your child have any birth injuries? |  |  | Specify: |

**Early Development**

Please give approximate ages if remembered, or comment on anything unusual

|  |  |  |
| --- | --- | --- |
| Developmental Milestones | Age Achieved | Comments/Details |
| Rolling Over |  |  |
| Sit Alone |  |  |
| Crawl |  |  |
| Walk |  |  |
| Chew Solid Food |  |  |
| Drink From a Cup |  |  |
| Say Words |  |  |
| Say Sentences |  |  |

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| --- | --- |
| What is your child’s preferred play position (sitting, standing, laying on stomach, etc)? |  |

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| --- |
| Please provide the following details about your child’s development |
|  | Yes | No | Details/Comments |
| Dislikes Lying on Stomach |  |  |  |
| Dislikes Lying on Back |  |  |  |
| Enjoys bouncing |  |  |  |
| Enjoys being upside down |  |  |  |
| Was/Is your child a toe-walker? |  |  | If yes, until what age? |
| Actively explored/moved around? |  |  |  |

**Visual Development**

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| In the past, has your child experienced any problems with his/her vision?  □ Yes □ No |
| If Yes, please explain: |
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| Are you aware of any current problems with your child’s vision? □ Yes □ No |
| If Yes, please explain: |
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| When was the last time his/her vision was tested? |
| What were the results? |

**Auditory Development**

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| Has your child had any problems with his/her hearing? (Operations, infections, tubes, etc.)  |
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| Ear Infections: □ Seldom □ Sometimes □ Often □ Never  □ Mild □ Moderate □ Severe |
| Are you aware of any current hearing problems? |
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**Family Members in the Home**

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| --- | --- | --- | --- |
| Name | Age | SexM / F | Relationship to child |
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| Marital Status of Parents: □ Married □ Separated □ Divorce □ Other: |
| How do you prefer information to be provided to you?  □ Verbal □ Written □ Both |

**Family Adaptation**

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| Have there been any specific events or traumas linked with the onset of your child’s difficulties: |
|  |
| What, if any, stresses are affecting your family at this time? |
|  |
| Which language(s) is spoken at home? |
|  |
| What do you enjoy most about your child and family? |
|  |
|  |
| How would you describe your child’s general adjustment at home? □ Poor □ Fair □ Good □ Excellent |

**Adoption (If applicable)**

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| Describe the circumstances surrounding the adoption: |
|  |

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| --- |
| Age when adopted: |
| # Prior foster homes:  |
| Is your child aware of his/her adoption? □ Yes □ No |

**School**

|  |  |
| --- | --- |
| School: | Grade in School:  |
| Teacher’s Name:  | Type of Classroom:  |
| Does your child have an IEP? □ Yes □ No |
| What Special Ed Services does your child have at school? □ OT □ PT □ ST □ Resource □ Other:  |

**Comments:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_