MOVING PARTS Therapy Services

PEDIATRIC CONFIDENTIAL HISTORY

Today's Date: _____ Child's Name: _____ Person(s) completing form: _____

Childcare/School: _____ School District _____Grade: _____

PAST HISTORY

Birth: Baby's weight at birth: _____ **□ yes □ no premature? How many weeks early? _____**

□ yes □ no forceps/vacuum delivery? **□ yes □ no labor medications? _____**

□ yes □ no cesarean delivery? **□ yes □ no long labor? How long? _____**

□ yes □ no oxygen required? How long? _____ **□ yes □ no intensive care? How long? _____**

□ yes □ no Pregnancy history (stress, nutrition, complications, infections, etc.)? Describe: _____

_____

□ yes □ no Other significant problems during/after birth (i.e., stuck in pelvis, birth injuries, etc.)?

Describe: _____

How well did your child nurse? _____

Describe your child's infancy (mood/affect, sleeping, etc.): _____

Has your child ever: □ yes □ no had any broken bones? □ yes □ no been in an accident? □ yes □ no had any operations?

Other medical health issues? _____

Developmental milestones (ages): First words _____ Crawled _____ Walked independently _____

CURRENT HISTORY

Does your child receive special education services? □ yes □ no (If yes, please attach IEP/Individualized Education Plan)

Please describe your child's living situation. Include home type (single family, apartment etc.) Include who lives in the home with your child and ages of siblings:

_____

_____

If your child has a diagnosis by a physician, please share: _____

When diagnosed? _____ Who made the diagnosis? _____

Is your child currently doing any alternative health programs? (ex. special diets, supplements or alternative therapies) □ yes □ no

_____

List any medications your child is taking and the purpose for taking each: _____

_____

Does your child have any precautions we should know about such as allergies, seizures, or special diets? _____

_____

Please circle any physical symptoms that apply:

Tubes in ears Ear infections Indigestion Stomachaches Eating difficulty Lack of dizziness Reflux/GI issues Constipation

Headaches Allergies Asthma Seizures Respiratory difficulty Heart ailments Inner tension Sinus trouble

Describe: _____

Emotional/behavioral symptoms: Often, my child can be described as: (please circle all that apply)

Cooperative willing to try new activities stubborn withdrawn separation difficulties destructive

avoids eye contact seems more tired than expected seems more active than peers restless impulsive

aggressive easily frustrated self-abusive easily distracted short attention span difficulty following directions

Present symptoms and child's major challenges: _____

_____

What seems to make things worse? _____

_____

What do you think may be going on with your child that is causing the problems? _____

What do you typically need to do when your child is having problems? _____

_____

Have they prevented your child from going to school? □ yes □ no Hospitalized child? □ yes □ no

What behaviors do you observe in your child when dealing with frustration/conflict? _____

_____

Difficulties at School? □ yes □ no Describe _____

At school, difficulty with (please circle all that apply):

Focus Following directions Sitting still Phy ed Sports Handwriting Keeping hands to self

Avoids coloring/writing Switches hands during coloring/writing

Difficulties with sleep? □ yes □ no Describe _____

Uses for sleep (please circle all that apply): weighted blanket Background noise Melatonin Medication

Sleeps in own bed Sleeps thru night If no, how many times and hours awake? _____

Bedtime: _____ Time child falls asleep: _____ Time child wakes in morning: _____

Describe sleep challenges: _____

Difficulty with mealtime (please circle all that apply): □ yes □ no Describe_____

At meals, difficulty with: Using fork/spoon Sitting through meal Spilling frequently Going to restaurants

Difficulty with Dressing: □ yes □ no Describe _____

Dressing difficulties (please circle all that apply): Zippers Tying shoes Staying on task Refuses to wear coat

Often puts clothes/shoes on backward Putting on coat, excluding zipper Puts coat on using a learned strategy

Difficulty with Daily Routine: □ yes □ no Describe _____

(Please circle all that apply): Difficulty with making transitions Seems more active than others Frequently trips/runs into things/falls down

Safety concerns □ yes □ no Describe _____

Safety (please circle all that apply): Does not come back when called Is unaware of dangers in public (strangers, crossing streets/parking lots)

Wanders off in public Difficulty going to stores Describe _____

Challenges with Play: □ yes □ no Describe _____

_____

Able to (please circle all that apply): Ride bicycle without training wheels Pump swing without help Accident prone

When playing avoids strenuous activity When playing, moves quickly between activities Tends to W-sit

Toileting skills:

Daytime accidents? □ yes □ no How often? _____ Nighttime accidents? □ yes □ no How often? _____

Percentage of time he/she initiates going without prompts _____

RELEASE OF INFORMATION		
Professional Type	**Name and Phone Number**	**Permission to Release**
Primary Physician & Clinic name		**□ yes □ no**
Specialist & Clinic name		**□ yes □ no**
Mental Health & Clinic name		**□ yes □ no**
OT/PT/SLP therapist & Clinic name		**□ yes □ no**
School or Daycare (educational/therapy staff, IEP team)		**□ yes □ no**
Autism services provider		**□ yes □ no**
Other		**□ yes □ no**

Guardian Signature: _____Date: _____

Printed Name: _____Relationship to client: _____

Is there anything else that would be good for us to know about your child to help the evaluation to go better?

_____

_____

_____

What are the <u>3 most important</u> things to you that you think we may be able to help your child improve?

Transitioning between activities (Please describe the challenge) _____

_____

Dressing (Please describe the challenge) _____

_____

Focus (what does this lack of focus make it difficult for your child) _____

_____

Sitting still (what does this make it difficult for your child to do) _____

_____

Sensory differences (what does this make it difficult for your child to do) _____

_____

Meals (please describe the challenge) _____

_____

Handwriting (please describe the challenge) _____

_____

Phy ed/sports (please describe the challenge) _____

_____

Runs into things/falls down (please describe) _____

_____

Keeping hands to self (please describe) _____

_____

Safety in the community such as stores, restaurants etc. (please describe the challenge) _____

_____

Other (please describe) _____

_____