Therapy Innovations

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Date: ____________________

IDENTIFYING INFORMATION

Child's Name: ______________________ Child's DOB: __________ Parent/Guardian Name:_________________________
If you are a guardian, do you have custody papers, DSS care, foster care, or power of attorney? ____ If yes, please provide a copy for our records.

Street Address:/ City: ____ Zip Code: __________________

Primary Contact Number: __________________________ Emergency Contact Number: ____________________________

Email address: ____

Primary Care Physician and Clinic:

____

Primary Insurance Provider: _____________________Secondary Insurance Provider: _______________________

Phone number for insurance company: ____

Policy Holder: ________________________________ Policy Holder: _____________________________________

Policy Number: _______________________________ Policy Number: ___________________________________

Group Number: _______________________________ Group Number: ___________________________________

MEDICAL & DEVELOPMENTAL HISTORY

Were there any pregnancy complications? _____ If yes, please explain.____
____
____

Length of pregnancy: _____ Was prenatal care received? _____ Mother's age at birth: _____
Were there any delivery complications? ____ If yes, please explain.____
____

The delivery was (please mark all that apply)
_____ Induced _____ Vaginal _____ C-Section _____ Emergency C-Section

Number of days in hospital following delivery: _______ Birth Weight: ________ Birth Height: _____
What hospital was your child born at? ____

Was your child transferred to another hospital? _____ If yes, where? ____
Did your child have any complications following delivery? _____ If yes, please explain.____________________________
____

Does your child have any medical diagnoses or medical concerns? _____ If yes, please explain. _____________________
____

Please list the age that your child met the following milestones:

_____Supported head independently
_____ Sat up alone
_____ Said first word
_____ Reached for objects
_____ Crawled
_____ Put 2 words together
_____ Rolled over
_____Walked without support
_____ Potty trained

List all allergies (seasonal, food, medications, etc.):____

Please list any medications, vitamins, or supplements the child is currently taking (or recently took, if pertinent):

Medication	Reason

Has your child had any ear infections? _____ If yes, how many and when? _______________________________________

Has your child ever been hospitalized? _____ If yes, please complete the box below.

When	How long	Reason

Has your child ever received any diagnostic testing? _____ If yes, please complete the box below.

Type of Test	When	Summary of Results

Has your child had any surgeries? _____ If yes, please complete the box below.

Type of Surgery	When	Reason/Complications

Please ***circle*** *an answer for the following statements:*

Does your child fall or lose balance easily? (YES) (NO)
What hand does your child use to write? (LEFT) (RIGHT) (UNKNOWN)
Child visually looks at people/toys? (YES) (NO)
Child shows negative response when touched or touching other objects? (YES) (NO)
Child enjoys movement such as swinging or roughhousing? (YES) (NO)
Do most people understand the child? (YES) (NO)
Does the child understand instructions? (YES) (NO)
Can your child independently manipulate fasteners such as zippers and buttons on clothing? (YES) (NO)
Does your child feed themselves without help? (YES) (NO)
Does your child brush their own teeth and hair? (YES) (NO)
Is your child independent with bathing? (YES) (NO)
Can your child cut with scissors independently? (YES) (NO)
Is your child able to go up and down stairs without help? (YES) (NO)
Can your child jump with 2 feet together? (YES) (NO)
Can your child balance on one foot? (YES) (NO)

FEEDING HISTORY

Did your child have difficulty latching or accepting a bottle following birth?_____ If yes, please explain how the child was fed. ____

Can your child feed him/herself? _____ If no, who feeds your child? _______________________________________
Does your child accept food from utensils?_____ If no, how does he/she eat food?____
____

What does your child drink from? Please check all that apply.
_____bottle _____sippy cup _____straw cup _____open cup _____other: ___________________________________

Will your child eat foods from the following food groups? If yes, please check.
_____meats _____dairy _____vegetables _____fruits _____grains

Is your child on a special or restrictive diet?_____ If yes, please explain.____
____
____

Will your child accept the following food consistencies? Please check all that apply.

_____ pureed food ex: applesauce _____ mixed textures ex: cereal & milk _____ hot food ex: oatmeal

_____ crunchy food ex: chips _____chewy food ex: gummy snacks _____ cold food ex: ice cream

Do you have any concerns regarding eating or feeding skills? _____ If yes, please explain.__________________

____

Please use this space if you had insufficient room to answer questions or if there is pertinent information regarding your child that you would like to add.