Southern New Hampshire Rehabilitation Services

Pediatric Center
5 George St., Hudson, NH 03051
Phone: 603-579-3601
Fax: 603-579-3607

PEDIATRIC REHABILITATION: GENERAL INFORMATION

SCHEDULING APPOINTMENTS

Your time is valuable, and we will make every effort to schedule appointments at a time that is convenient for you and your child. As you schedule appointments for your child, please consider the following suggestions:

- Your child will be given a **therapy appointment time** (that should remain consistent) throughout your child's need for services. It is your responsibility, however, to ensure that your child is indeed *scheduled* for his/her therapy visits.

- Once you know how often your child will need therapy, schedule as many upcoming appointments as possible. Please do not wait until your last scheduled appointment to make more appointments. We would rather cancel unused appointments than have your child miss getting the time that he/she needs. Please request a print-out copy of your child's schedule from the Front Desk staff for your records.

- If your scheduling needs change, please contact your child's therapist directly. Your request for a schedule change will be accommodated as the therapist's availability allows. If the time you have requested is not immediately available, your child may be placed on a treatment waiting list.

IF YOU CANNOT KEEP AN APPOINTMENT

- Regular attendance is essential to your child achieving the best results from his/her therapy program. If you are unable to keep an appointment, please call us with **24 hours advance notice** at (603) 579-3601. (If you miss two consecutive appointments without proper notice or have inconsistent attendance, your child's services may be suspended.)

- Please be sure to keep our office updated with home, work, and cell phone numbers and indicate the best way to reach you in the event that we need to contact you. If you would also like to be contacted by email, please provide your email address.

IMPORTANT INSURANCE INFORMATION

- Insurance coverage varies greatly. **You are responsible for knowing and understanding your insurance coverage/benefit information.** This information is usually found in your plan's Certificate of Coverage or by calling customer service. We are happy to help you to understand your child's diagnosis and need for therapy so that you are able to share that with your insurance company.

- You are responsible for paying any co-payments, co-insurance, or deductibles, depending on your insurance carrier. You may either make co-payments at each visit or weekly if you come more than once per week. If you do not make your co-payment here, you will receive a bill from Southern New Hampshire Medical Center.

- If you do not have insurance, you will receive a bill for therapy. Please contact our financial counselors if you would like to apply for financial assistance, or our collection office if you would like to make payment arrangements. The numbers are listed below:

Financial Counselor:
577-2241 or 577-2264

Budget and Payment Options - Patient's Last Name begins with:

A-C	577-7873
D-G	577-7880
H-L	577-7877
M-Q	577-7878
R-Z	577-7872

- Most insurance companies now require authorization or pre-authorization for therapy sessions (each session must be authorized). Each plan has different requirements. Some require the authorization from your primary care provider (PCP), some from your referring provider (which may be your PCP or may be a specialist such as a neurologist), and some require authorization from a review process at your insurance company. Tips to avoid delays in your schedule are:

  - ✓ Contact your PCP and start the process early. Bring **all** the paperwork that he/she gave you.
  - ✓ **Come to therapy with all insurance cards and authorization or referral numbers that you have.**
  - ✓ Share all clinical information with your therapist.
  - ✓ Let the Front Office Staff know if you have had a change of insurance to avoid interruptions to therapy sessions. Often, new authorizations must be obtained prior to a continuation of services.

EVALUATION REPORTS/WRITTEN DOCUMENTATION

- Evaluation reports will be sent to the individuals that you have authorized via written permission on the *Consent to Release Medical Information Form*. Please allow approximately 4 weeks for receipt of the report.

- Please notify your child's therapist **as soon as possible** if another servicing provider (e.g., primary care physician, specialist, therapist, teacher, etc.) is in need of written documentation of your child's progress and/or therapy goals. Every accommodation will be made to forward this information to the requested individual in a timely manner; however please allow at least 10 business days for this documentation to be provided. A *Consent to Release Medical Information Form* will need to be completed prior to the information being sent to the requested individual.

QUESTIONS, CONCERNS, OR COMPLIMENTS

Our promise is to provide you with the best possible service for your child, by a highly skilled professional, in a clean and comfortable setting. Our goal is to work together with you as a team to facilitate progress toward your child's goals.

We routinely survey our patients. It is one of the few methods we have to see how we are doing in meeting our patient's needs. Your opinion has an immediate and direct effect on how we serve our patients. The information has been the start of many important changes. We appreciate your participation and welcome any feedback about your family's experience with our pediatric therapy services.

Please share your thoughts with your therapist at any time. If you do not feel comfortable sharing your concerns with your therapist, you may discuss them directly with the Director of SNHRC. Please contact:

Kathleen Pierce, DPT, MS, OCS
Director – SNHRC
17 Prospect Street
Nashua, NH 03060

Or Call: (603) 594-6055

If you are satisfied with our services and facility, please recommend us to others.

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PEDIATRIC REHABILITATION: WORKING TOGETHER

The best way to get the most from therapy is to follow these tips:

- **Share your questions.** The more information you have, the more you can participate in your child's therapy program. It is important that you understand your child's initial evaluation and treatment plan so that you may participate in setting goals.

- **Be on time.** Because our therapists see patients consecutively, your child may have less time with his/her therapist if you are late to a session. If you are more than 10 minutes late, your appointment may be rescheduled.

- **Carry out home programs as assigned.** The therapist will design a home program for your child's specific needs. Please complete and return the homework sheets as directed if given to you by your child's therapist. This helps to determine which new activities will be included in handouts for the following week/month.

- **Practice whenever possible.** To benefit most from any type of therapy, practice is essential. Working on new skills outside of scheduled therapy time has the greatest effect on progress towards goals. As such, we strongly encourage parents to provide opportunities for their children to practice their new skills by engaging in recommended activities and try suggested strategies with their children at home and in the community. This will also help to promote generalization of skills to home and other settings.

- **Involve caregivers and family members.** You are welcome to involve your child's caregivers in therapy as you deem appropriate. Often, they can encourage and support your child's efforts during those times when you are not available.

- **Be present for therapy.** It is suggested that you make arrangements (whenever possible) for your other children so that you may participate in your child's therapy. This ensures that you know what new skills and strategies your child is learning and promotes your ability to offer support and cueing at home.

Please note: If the patient is a minor, a parent must be present (on the premises) during sessions.

Southern New Hampshire Rehabilitation Services

Attendance Policy

We at Southern New Hampshire Rehabilitation Center tailor the frequency and duration of your treatment to meet your specific rehabilitation needs and goals. Your consistent attendance of the planned treatment regimen is important for your full recovery. We strive to provide patients with a higher level of care by scheduling an appointment for each patient. Cancellations, especially last minute ones, along with patient no-shows, jeopardize your recovery and decrease our ability to provide one on one care to you and our other patients.

Every effort is made to keep on schedule so we respectfully ask patients to be prompt and to keep their appointments. Our clinic's policy regarding appointments is as follows:

- We remind patients of their appointments two days in advance with an automated reminder call. An appointment list is also printed at the time of scheduling and given to you.
- If you need to change or cancel your appointment, we request at least 24 hours notice.
- If you accumulate 2 no-shows and/or cancellations, your therapist may refer you back to your physician before scheduling another appointment, allow only same day appointments, or may choose to discharge you from therapy and report this to your physician/provider.
- It is your responsibility to inform the Front Desk Staff if you arrive late for a scheduled appointment. If you arrive more than 10 minutes late your appointment may be rescheduled, and will be considered an absence.

The satisfaction of all of our patients is important to us. We thank you in advance for your cooperation with this attendance policy.

I understand and agree to comply with the above attendance policy.

Name:_____Date:_____

Staff:_____Date:_____ ___

AD0031

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3 Day Diet History Form

Instructions:
You are being asked to record all foods and drinks ingested by your child for 3 days in a row. The following directions will guide you in filling out the form. **You need to complete the 3 day diet history and return it with the rest of the forms**.

1. Please fill out ALL the information at the top of the first page.

2. Please record the DATE and DAY of the week for each day. Record ALL food and drinks eaten along with the TIME your child ate or drank them. It is best to carry the history form with you and to record items immediately so that nothing is missed.

3. Include an EXACT description of the item and your best guess of the portion size of the amount eaten. Write the brand name of formula your child is on (i.e. Enfamil, Prosobee, etc.), what type of juice he/ she drank (i.e. apple, grape, etc.), any special recipes for drink mixtures your child uses (i.e. 24 calorie Isomil + 1 tsp Polycose), and any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine). Be sure to include dressings, sauces, gravies, or anything extra.

4. It is suggested that you may wish to use measuring spoons and cups when serving your child for these 3 days to report the amounts ingested.

Example:

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Mouth	G-tube
1/1/02	4 pm	Gerber applesauce #2	1 ounce			✔	
		White Bread	¼ slice			✔	
		Ham lunch meat	½ ounce			✔	
		Mayonnaise	1 tsp			✔	
		White grape juice	1 ounce		✔	✔	
	7 pm	Similac Formula	4 ounces	✔		✔	
	9 pm	Pediasure with fiber	8 ounces				✔

3 Day Diet History

Child's Name: _____ Date of Birth: _____

Formula Mixing: Number of scoops: _____

Amount of Water: _____

Other Additives: _____

Date	Time & Length of Mealtime	Food/ Drink Item	Amount	Bottle	Cup	Mouth	G-tube

Date	**Time & Length of Mealtime**	**Food/ Drink Item**	**Amount**	**Bottle**	**Cup**	**Mouth**	**G-tube**

3 Day Diet History Form

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PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

1. Please explain in your own words, what your child's current feeding problem is:

2. Was your child breast fed? From when to when _____

   Was your child bottle fed? From when to when _____

   Please describe your child's initial skill on the breast and/or bottle:

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit, or pull off the nipple? Circle the behaviors shown and describe when they would happen, why, and for how long:

4. Describe how the weaning process off the breast and/or bottle went and why the child was weaned:

5. At what age did your child transition to Baby cereal? _____ Baby food? _____

   Finger foods? _____Transition fully to table food? _____

Please describe how these transitions were handled by your child, especially if any difficulties happened:

IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

6a. List the foods that your child currently eats and drinks (put a star next to their favorites):

6b. List the foods your child refuses:

6c. List any current food allergies or sensitivities: _____

_____

6d. Does your child see an allergist? If so, please list name and address: _____

_____

6e. Describe your child's mealtime:
Who typically feeds your child? _____
Who typically eats with your child? _____
What type of chair is used? _____
How long are meals typically? _____

Does your child use utensils or any type of special cups/bowls (describe)? _____

Are there any other activities going on at meals? What activities (describe)? _____

6e. What times does your child typically eat and what type (bottle, breast, solids)?

IF YOUR CHILD IS TUBE FED, PLEASE ANSWER THE FOLLOWING QUESTIONS:
7a. What type of formula is used and how do you mix it?

7b. Please detail your child's feeding schedule below:

Time of feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate

7c. Describe where your child is tube fed and what activities are occurring at the same time:

7d. Describe your child's reactions to the tube feedings (connecting, during, disconnecting):

*****PLEASE ANSWER FOR ALL CHILDREN**

8. Has your child ever been on any type of special diet other than what you just described? _____
   If yes, please describe type of diet, at what ages, why, and your child's response:

9. How do you know your child is hungry or full? _____

10. Current height: _____ weight: _____ As of: _____

11. Has your child lost or gained any weight in the last 6 months, and how much? _____

12. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

13. Does your child have/had any of the following problems? Please describe:
    Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing

14. Does your child take a vitamin supplement? Which one? _____

15. Describe how you and your child feel after a feeding:

    You:

    Your child:

16. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told?

17. What treatments have been tried for this problem and what were the results?

18. How can we be most helpful to you and your child?

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Sensory History

For each question, place a check in the column that best describes your child. (Please compare with other children you know of the same age.)

QUESTIONS		Often	Sometimes	Rarely
	Does your child:			
	1. Object to being touched?	1		
	2. Seem irritable when held?	2		
	3. Isolate self from other children?	3		
	4. Avoid/dislike getting hands messy?	4		
	5. Become upset when face is being washed?	5		
	6. Become upset when having hair combed, fingernails clipped or teeth brushed?	6		
	7. Prefer long sleeve clothing, sweaters or jackets even when it's warm?	7		
	8. Seem sensitive to certain fabrics and avoid wearing clothes made of them?	8		
TACTILE SENSATION	9. Have trouble changing to new types of clothing when seasons change? (i.e. From long pants to shorts)	9		
	10. Avoid going barefoot? (i.e. In sand or grass)	10		
	11. Become irritated by tags on clothing?	11		
	12. Seem to crave being held or cuddled?	12		
	13. Express discomfort when touched by other people, even as in a friendly hug or pat?	13		
	14. Tend to bump or push others?	14		
	15. Seem overly sensitive to pain? (i.e. Especially bothered by small cuts)	15		
	16. Seem less sensitive to pain than others? (i.e. To falls and bruises)	16		
	17. Mouth objects or clothing often?	17		
	18. Have difficulty judging how much strength to use? (i.e. when petting animals may use too much force)	18		
	Does your child:			
	19. Seem overly sensitive to sound?	19		
	20. Seem confused about the direction of sounds?	20		
AUDITORY SENSATION	21. Like to make loud noises?	21		
	22. Become distracted or have trouble if there is a lot of noises around?	22		
	23. Respond negatively to unexpected or loud noises?	23		
	Does your child:			
GUSTATORY SENSATION	24. Act as though all food tastes the same?	24		
	25. Explore by tasting?	25		
	26. Dislike foods of a certain texture?	26		
	27. Chew or lick non-food items?	27		
	Does your child:			
	28. Explore objects by smelling them?	28		
OLFACTORY SENSATION	29. Discriminate odors?	29		
	30. React defensively to smell?	30		
	31. Seem bothered by smells that most other people don't notice?	31		

QUESTIONS		Often	Sometimes	Rarely
Does your child:				
	32. Become easily distracted by visual stimulation?	32		
	33. Express discomfort at bright lights?	33		
VISUAL	34. Avoid or have difficulity with eye contact?	34		
SENSATION	35. Have a hard time picking out a single object from many? (i.e. Finding a specific toy in the toy box)	35		
	36. Have difficulty with a camera flash, seems irritated by it?	36		
Does your child:				
	37. Chew or lick non-food items?	37		
	38. Seem fearful in space (i.e. Going up & down stairs, riding a tricycle?)	38		
	39. Appear clumsy, often bumping into things &/or falling down?	39		
	40. Prefer fast-moving, spinning carnival rides?	40		
	41. Have poor balance?	41		
	42. Become anxious or distresed when his/her feet leave the ground?	42		
	43. Avoid climbing or jumping?	43		
VESTIBULAR	44. Dislike elevators or escalators?	44		
SENSATION	45. Dislike riding in a car?	45		
	46. Dislike activities where head is upside down or when lifted overhead? (such as with hair washing or somersaults)	46		
	47. Loved to be tipped upside down or lifted overhead?	47		
	48. Seek out all kinds of movement activities?	48		
	49. Jump a lot on beds or other surfaces?	49		
	50. Like to spin him/herself?	50		
	51. Bang his/her head on purpose?	51		
	52. Throw him/herself against the floor, wall or other people for enjoyment? (likes to "crash")	52		
	53. Take unusual risks during play?	53		
Does your child:				
	54. Manipulate small objects easily?	54		
	55. Seem accident prone			
COORDINATION	(i.e. Have frequent scrapes and bruises)?	55		
	56. Neglect one side of the body or seem unaware of it?	56		
	57. Use one hand more than the other?	57		
Does your child:				
	58. Need assistance to feed him/herself?	58		
	59. Tend to eat in a sloppy manner?	59		
	60. Frequently spill liquids?	60		
FEEDING	61. Drool?	61		
	62. Have trouble chewing?	62		
	63. Have trouble swallowing?	63		
	64. Have difficulity eating foods with lumps?	64		
	65. Stuff or put too much food in his/her mouth?	65		

*Adapted from Pat Wilbarger, OTR, Special Education Workshop. St. Paul Public Schools, St. Paul, Minnesota, August 1973.
Sensorimotor Integration for Developmentally Disabled Children: A Handbook Montgomery, P., Richter.

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TODAY'S DATE: _____

PEDIATRIC FEEDING AND SWALLOWING TEAM

FAMILY AND MEDICAL HISTORY FORM

PART 1 - GENERAL INFORMATION

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____ CELL PHONE(S): _____ WORK PHONE: _____

COMPOSITION OF FAMILY IN WHICH CHILD CURRENTLY RESIDES (Primary Caregivers)

FATHER'S NAME: _____ DATE OF BIRTH: _____

OCCUPATION: _____

HIGHEST EDUCATIONAL LEVEL: _____ RELIGION: _____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

MOTHER'S NAME: _____ DATE OF BIRTH: _____

OCCUPATION: _____

HIGHEST EDUCATIONAL LEVEL: _____ RELIGION: _____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

BIOLOGICAL PARENT INFORMATION (if not current caregiver or different from above):

FATHER'S/MOTHER'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE #: _____

IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD?

ADDRESS: _____

PHONE#: _____ WHEN IS CHILD IN THIS CHILDCARE? _____

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:

NAME SEX AGE RELATIONSHIP TO CHILD

FAMILY STRESSORS (please note/explain if any of the following stressful events happened in the last 12 months):

ITEM	NO	YES	EVENT	EXPLANATION
1			Marital separations/divorce	
2			Death in the family	
3			Financial crisis	
4			Job change/difficulties	
5			School problems	
6			Legal problems	
7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event	

PART 2: PREGNANCY AND BIRTH HISTORY

Please list all pregnancies in order (including this child, miscarriages, terminations or deceased):

PREGNANCY#	BIRTH WEIGHT	ANY DELIVERY, HEALTH OR DEVELOPMENTAL PROBLEMS	FATHER
1			
2			
3			
4			
5			
6			

PRENATAL HISTORY:

1. Did you have any problems getting pregnant? Please describe: _____
2. In what month did you begin prenatal care? _____
3. Please list all over the counter medications taken during this pregnancy and when (eg. vitamins, antacids, cold medications, aspirin etc): _____
4. Please list any cigarettes, caffeine, street drugs taken (how much a day and when in pregnancy): _____
5. Please list all prescription medications taken (name, dosage and from when to when): _____

6. Please give in pounds, the amount of total weight lost and/or gained during this pregnancy:_____

7. Did you have any of the following events occur during this pregnancy? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Allergies or asthma	
2			Anemia	
3			Diabetes/blood sugar problems	
4			Edema (swelling, water retention)	
5			Excessive vomiting	
6			Headaches/migraines	
7			Heart disease	
8			Kidney disease	
9			Pre-eclampsia	
10			Rh negative	
11			Toxemia	
12			Toxin exposure	
13			Accidents	
14			Bleeding/spotting	
15			Blood transfusions	
16			Cervical incompetence	
17			Infections (bladder or genital)	
18			Infections (other)	
19			Pre-term labor	
20			Uterine or uterine fluid problems	
21			Other physical injury	
22			Other not specified problem	

BIRTH HISTORY (for the child being evaluated):

1. Hospital where born + city + state: _____

2. Physician's Name: _____

3. Gestational Age at time of delivery (or # weeks early or late): _____

4. Length of Labor (in hours)? _____ Length of membrane rupture? _____

5. Any type of labor stimulation and what was used? _____

6. Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?

Pain relief _____ Anti-vomiting _____

Sedation _____ Anesthesia _____

7. What type of delivery (please circle)? Vaginal Cesarean Section = elective or emergency

Presentation: Head, Face, Breech, Transverse Reason for C-section _____

Assistance: Forceps, Vacuum, other _____

8. Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the “no” or “yes” column and explain (why, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			MATERNAL infection	
2			Low/high red/white blood cell count	
3			Pelvis or cervical problems	
4			Placenta problems	
5			Dysfunctional labor	
6			BABY had the cord around the neck	
7			Cord problems (knots, prolapsed, compression)	
8			Baby had very low or high heart rate	
9			Baby had heart rate decelerations	
10			Fetal distress was noted	
11			Meconium was noted	

9. How soon after the delivery did you see your baby? _____

10. What was the baby’s APGAR scores? 1 minute _____ 5 minute _____

11. What was the baby’s Birth Weight? _____ Birth Length _____

12. Number of Days spent in the nursery? _____NICU or Newborn Nursery? _____

13. What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the “no” or “yes” column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Was blue/cyanotic at birth	
2			Required stimulation to breathe	
3			Required oxygen at birth	How much/what type?
4			Required resuscitation	
5			Was considered small for gestational age	
6			Had tremors or seizures	Which/for how long?
7			Very low tone	
8			Brain hemorrhage	
9			Anemia and/or transfusions	Which/how many times?
10			Jaundice (yellow)	How much/how treated?
11			Had bruising	
12			Rh incompatibility problems	
13			Infections	
14			Congenital birth defects	
15			Aspiration (meconium or fluid)	Which/how treated?
16			Respiratory distress signs or syndrome	
17			Needed ventilation	What type/how long?
18			Choking or vomiting episodes	
19			Tube feedings	

20			Needed medications	

PART 3: MEDICAL HISTORY OF CHILD

HOSPITALIZATIONS AND/OR SURGERIES:

List the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reasons.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	
24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	

27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			Major medical procedures (detail below)	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

PRESENT HEALTH STATUS:

Please note any illnesses for which your child is currently being treated:_____

_____

_____

Current medications: _____

_____

Medication allergies: _____

PART 4: DEVELOPMENTAL HISTORY

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
MOTOR MILESTONES							
Smiled							
Held head up							
Rolled over							
Reached for an object actively							
Transferred object between hands							
Sat unsupported							
Crawled							
Stood alone							
Walked by self							
Threw objects actively							
Ran by self							
Ate unaided with a spoon/fork							
Dressed self							
Rode bicycle without training wheels							
Caught a thrown object							
Demonstrated handedness (which?)							
SPEECH/LANGUAGE MILESTONES							
Said first words							
Followed simple 1 step directions							
Said 2-3 word phrases							
Knows body parts							

Current speech/language skills:							

1. Do you feel your child was “faster” or “slower” than his/her peers in any other way? Please explain _____

_____

2. Name of current school: _____ Grade: _____

Address: _____ Phone: _____

Any special educations services (which, when)?_____

Teacher:_____

Describe any other concerns shared by the teacher: _____

_____

PART 5: FAMILY MEDICAL HISTORY

Are there any of the following medical problems on either side of the child’s BIOLOGICAL parents’ families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to the CHILD. Please also explain if medications, surgery or hospitalizations were needed.

ITEM	NO	YES	DESCRIPTION	MOTHER’S OR FATHER’S SIDE	WHO?	EXPLANATION
1			Birth defects/Congenital disorder			
2			Neurological disorder or seizures			
3			Respiratory disease or tuberculosis			
4			Hormonal or Gland disorder			
5			Allergies - food or environmental (specify which for whom)			
6			Diabetes			
7			Stomach disease/disorder/problems			
8			Senses problems - vision, hearing, touch, taste, smell, balance			
9			Swallowing or feeding problems			
10			Attentional/learning problems			
11			Hyperactivity			
12			Alcohol/drug problems			
13			Psychological/nervous issues			
14			Other			

Please share any other information you would like us to know about your child

To the best of my knowledge, this information that I have provided is accurate and complete.

_____ _____

Signature of Parent or Guardian **Date**

_____ _____

Therapist Signature **Date**