MOVING PARTS Therapy Services

# PEDIATRIC CONFIDENTIAL HISTORY

Today's Date: _____Child's Name: _____

Childcare/School: _____

Grade: _____ Person(s) completing form: _____

## PAST HISTORY

Birth: Baby's weight at birth: _____

□ yes □ no premature? How many weeks early? _____

□ yes □ no forceps/vacuum delivery? no □ yes □ cesarean delivery?

□ yes □ no labor medications? _____

□ yes □ no long labor? How long? _____

□ yes □ no oxygen required? How long? _____

□ yes □ no APGAR score concern? _____

□ 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 (please fill in ages):

First words _____ Crawled _____ Walked independently _____

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# 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. Please 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: _____

Please check any emotional/behavioral symptoms that apply:

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

cooperative willing to try new activities stubborn withdrawn separation difficulties

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

restless impulsive destructive aggressive easily frustrated self-abusive

easily distracted short attention span difficulty following directions immature behavior

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? _____

_____

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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 with School?** □ yes □ no Describe _____

Difficulty with: focus □ yes □ no following directions □ yes □ no sitting still □ yes □ no

Phy ed □ yes □ no handwriting □ yes □ no keeping hands to self □ yes □ no

Switches hands during coloring/writing? □ yes □ no Avoids coloring/writing? □ yes □ no

**Difficulties with sleep?** □ yes □ no Describe _____

_____Uses: weighted blanket □ yes □ no

Background noise □ yes □ no Melatonin □ yes □ no Medication □ yes □ no

Sleeps in own bed □ yes □ no Sleeps thru night □ yes □ no If no, how many times awake? _____

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

Describe challenges: _____

_____

**Difficulty with Mealtime:** □ yes □ no Describe_____

_____

Difficulty with: using fork/spoon □ yes □ no sitting through meal □ yes □ no

spilling frequently □ yes □ no going to restaurants: □ yes □ no

**Difficulty with Dressing:** □ yes □ no Describe _____

_____

Difficulty with: zippers □ yes □ no tying shoes □ yes □ no staying on task □ yes □ no

My child: refuses to wear coat □ yes □ no often puts clothes/shoes on backward □ yes □ no

puts on coat, excluding zipper □ yes □ no puts coat on using a learned strategy □ yes □ no

**Difficulty with Daily Routine:** □ yes □ no Describe _____

_____

Difficulty with making transitions □ yes □ no My child seems more active than others □ yes □ no

More often than peers, my child: trips □ yes □ no runs into things □ yes □ no falls down □ yes □ no

**Safety concerns** □ yes □ no Describe _____

_____

Difficulty going to stores: □ yes □ no Describe _____

My child often: wanders off in public □ yes □ no does not come back when called: □ yes □ no

is aware of dangers in public (strangers, crossing streets/parking lots, etc.): □ yes □ no

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**Challenges with Play:** □ yes □ no Describe _____

_____

Difficulty with: sports □ yes □ no Describe _____

Able to: ride bicycle without training wheels □ yes □ no pump swing without help □ yes □ no

When playing: avoids strenuous activity □ yes □ no moves quickly between activities □ yes □ no

tends to W-sit □ yes □ no accident prone □ yes □ no Seems to have weak muscles □ yes □ no

**Toileting skills:**

Daytime accidents? □ yes □ no How often? _____

Nighttime accidents? □ yes □ no How often? _____

Percentage of time he/she initiates going without prompts _____

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| RELEASE OF INFORMATION | | |
|---|---|---|
| **Professional Type** | **Name and Phone Number** | **Permission to Release** |
| Primary Physician & Clinic name | | □ yes □ no |
| Specialty Physician & 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: _____