Stepping Stones Therapy
for kids

OCCUPATIONAL, PHYSICAL & SPEECH THERAPY

OCCUPATIONAL THERAPY/PHYSICAL THERAPY
PATIENT INFORMATION

BACKGROUND:

Please fill out the questionnaire as completely as possible. Additional written comments are welcome. If you have questions,contact Stepping Stones Therapy for Kids and your question will be directed to the appropriate therapist. Thank you.

Child's name: _____ Today's Date: _____
Child Date of Birth: _____ Age: _____ Gender: M or F
Pediatrician: _____
FAMILY INFORMATION:
1.Parent/Guardian's name: _____
Phone: _____ Email: _____
2.Parent/Guardian's name: _____
Phone: _____ Email: _____
Number of children in family and ages: _____
_____
Are there any family members or relatives who have had sensory processing difficulties, fine motor delay, gross motor delay, visual difficulties, or developmental delay?: _____

_____

Parent 1 Occupation: _____
Parent 2 Occupation: _____

LANGUAGE INFORMATION: What is your child's ethnicity? _____ What is your child's primary language? _____ Is another language spoken in your home? _____ If yes, what other language is spoken? _____ Does your child speak a second language? _____ If yes, what other language is spoken? _____

AREA OF CONCERN:

Reason for seeking evaluation and/or therapy:

_____

_____

_____

Has your child received previous evaluation and/or therapy? YES or NO (If yes, please list the type of help, dates of service, and the name of the professional or agency involved.) _____

_____

How does your child get around their environment (crawls, walks, w/c, etc.): _____

Does your child use any adaptive equipment?: _____

When did you first notice your child's difficulties, and how were they apparent to you?: _____

_____

DEVELOPMENTAL HISTORY:

Prenatal History

Mother's age at birth: _____ Father's age at birth: _____

Did the mother take any medications during pregnancy? _____If yes, please list _____

_____

Werethere complications during pregnancy such as illness, Rh negative, German measles? If yes, please describe: _____

_____

_____

Was the baby full term? _____

If premature, give: Month: _____ Weight: _____

What was the length of labor?: _____ Induced?: _____Cesarean?: _____

Medication during delivery: _____APGAR score: __Were forceps used?: _____

Time in NICU?: _____Time on ventilator/oxygen?: _____

Were there other complications such as:

Difficulty breathing_____ Difficulty Sucking _____Tube Feed _____Difficulty Feeding _____Seizures _____

Birth Defect_____ Incubation _____Transfusions _____ Extended Hospital Stay_____ Jaundice _____

Rubella ____Herpes Syphilis ____Sepsis ____Other (Please Specify)_____

Was your child breast fed?: _____ If yes, how many weeks/months?:_____

Did your child have difficulty breast feeding?:_____ If yes, explain: _____

Did your child have difficulty using the bottle?:_____ If yes, explain: _____

Additional Comments:_____

_____

Infancy/Toddler History

Give age as near as possible:_____

Rolled over: _____crawled: _____sat alone: _____walked: _____

talked (simple words): _____ talked (sentences): _____

Check behaviors which describe your child as an infant:

___cried a lot, fussy, irritable	___like being held	___tense when held
___good, non-demanding	___resisted being held	___very active
___alert	___drooled excessively	___good sleep patterns
___quiet or passive	___floppy when held	___irregular sleep patterns

Other (Please Specify)

Medial History:

Has your child had any of the following? If yes, please give dates:

Meningitis:_____ High temperatures: _____ Seizures: _____

Ear infections: _____

Allergies (latex, food, other): _____

_____

Physical injuries (describe and date): _____

_____

Surgeries/Medical procedures (describe and date):_____

_____

Hospitalizations (describe and date):_____

_____

Medical diagnosis such as diabetes, epilepsy, heart trouble, autism, ADHD: _____

_____

Has your child has a hearing test?: _____Results: _____

Does your child wear glasses?_____Had an eye exam recently?Results: _____

Past medications: _____

_____

_____

Current medications: _____

_____

_____

Other medical history: _____

_____

_____

Educational History

Name of school: _____ Teacher's Name: _____

Grade:_____ Full time? YES or NO (if no, please list any other school(s) or daycare he/she attends, as well as how often: _____

Does your child receive services for school? _____ If yes, please explain:_____

_____

Please describe your child's relationship with teacher: _____

_____

Relationship with classmates: _____

_____

Areas of academic difficulty: _____

_____

_____

Areas of most success or enjoyment: _____

_____

Does your child require adaptation in the classroom (describe)? _____

_____

Social/Emotional:

Please indicate any of the following behaviors and provide explanation as needed.

Does your child:	N	R	S	O	A	Index:
Become overly aggressive?						N=never
Become overly passive?						R=rarely
Become frustrated easily?						S=sometimes
Seem sensitive to criticism?						O=often
Seem difficult to motivate?						A=always
Often appear anxious?						
Often laugh or smile?						
Have variations in moods?						
Have difficulty adjusting to changes?						
Seem fearful of new tasks?						
Have temper tantrums?						
Have poor eye contact?						
Avoid demonstrating affection?						
Avoid group activities?						
Wet the bed after 3 years of age?						
Have trouble learning urinary control?						
Have trouble learning bowel control?						
Interacts well with peers?						

Extracurricular activities: _____

Least favorite activities: _____