Stepping Stones Therapy
for kids
Occupational, Physical & Speech Therapy
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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:
Parent/Guardian's name:
Phone: Email:
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?:

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

Were there 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:

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 he/she participates in:

Favorite activities:

Least favorite activities: