



# Sensory Solutions, LLC

Physical, Speech and Occupational Therapy for Children

## Patient History Form

**\*Please fill out the questionnaire as accurately and completely as possible.**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Referred by: \_\_\_\_\_

What are your concerns regarding your child? \_\_\_\_\_

\_\_\_\_\_

Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Address \_\_\_\_\_

Zip Code: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Siblings (and ages): \_\_\_\_\_

Marital Status (Please check):  Married  Separated  Divorced  Widowed  Single

Medical Insurance Company: \_\_\_\_\_

Whom will be responsible for payments: \_\_\_\_\_

Emergency contact information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Child's Pediatrician: \_\_\_\_\_

Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

How long has your child been under this physician's care?: \_\_\_\_\_



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## MEDICAL HISTORY:

Pregnancy:  Full Term  Premature

Length of Pregnancy: \_\_\_\_\_

Mother's general health during pregnancy:  Good  Fair  Poor

Problems encountered during pregnancy (e.g., illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Length of total labor: \_\_\_\_\_

Difficult labor:  Yes  No

Delivery Type:

Vaginal

C-section

Complications:

Induced Birth

Breech Presentation

Limpness

Stiffness

Other: \_\_\_\_\_

Elaborate on above delivery complications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Length of hospitalization: \_\_\_\_\_ Child's birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Complications:

Jaundice

Cyanosis

Congenital defects

Other: \_\_\_\_\_

Was there a need for:

Oxygen

Transfusions

Tube Feedings

If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

Were there any feeding difficulties at birth:  Yes  No

Explain: \_\_\_\_\_  
\_\_\_\_\_



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Problems encountered during your child's first month: \_\_\_\_\_

List illnesses/diseases your child has experienced:

Illness: \_\_\_\_\_ Age: \_\_\_\_\_

Illness: \_\_\_\_\_ Age: \_\_\_\_\_

Illness: \_\_\_\_\_ Age: \_\_\_\_\_

List injuries/operations your child has had:

Injury/operation: \_\_\_\_\_ Age: \_\_\_\_\_

Injury/operation: \_\_\_\_\_ Age: \_\_\_\_\_

Injury/operation: \_\_\_\_\_ Age: \_\_\_\_\_

Has your child experienced high fevers:  Yes  No

Age: \_\_\_\_\_ Temp: \_\_\_\_\_ Frequency: \_\_\_\_\_

Has your child experienced convulsions/seizures:  Yes  No

Age: \_\_\_\_\_ Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Medication: \_\_\_\_\_

Has your child experienced ear infections:  Yes  No Frequency: \_\_\_\_\_

Has your child had tubes placed:  Yes  No When: \_\_\_\_\_

Date of last hearing evaluation: \_\_\_\_\_ Results: \_\_\_\_\_

Where was the hearing evaluation completed: \_\_\_\_\_

Date of last vision evaluation: \_\_\_\_\_ Results: \_\_\_\_\_

Where was the vision evaluation completed: \_\_\_\_\_

Allergies:

None

Seasonal

Food

Other

Please list all allergies: \_\_\_\_\_

History of acid reflux:  Yes  No

If yes, when and how was it treated: \_\_\_\_\_

Child's general health at present:

Good

Fair

Poor



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Is your child currently taking any medications: \_\_Yes \_\_No

If yes, type(s): \_\_\_\_\_

## SPECIALTY CONTACTS:

Specialty	Name of Agency/Specialist	Address	Phone
Audiologist	_____	_____	_____
Behavior Therapist	_____	_____	_____
Cardiologist	_____	_____	_____
Chiropractor	_____	_____	_____
ENT	_____	_____	_____
Occupational Therapist	_____	_____	_____
Ophthalmologist/ Optometrist	_____	_____	_____
Orthopedist	_____	_____	_____
Physical Therapist	_____	_____	_____
Psychologist/ Psychiatrist	_____	_____	_____
Speech Pathologist	_____	_____	_____
GI	_____	_____	_____
Other	_____	_____	_____



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## DEVELOPMENTAL HISTORY:

Check which of the following describes/described your child as an infant:

- Fussy
- Irritable
- Good
- Quiet
- Passive
- Active
- Liked being held
- Resisted being held
- Floppy when held
- Tense muscles when held
- Good sleep patterns
- Irregular sleep patterns

Check which of the following describes your child at present:

- |  |  |
|--|--|
| <input type="checkbox"/> Usually happy                                 | <input type="checkbox"/> Poor attention span               |
| <input type="checkbox"/> Mostly quiet                                  | <input type="checkbox"/> Easily frustrated                 |
| <input type="checkbox"/> Overly active                                 | <input type="checkbox"/> Cries often                       |
| <input type="checkbox"/> Tires easily                                  | <input type="checkbox"/> Cries infrequently                |
| <input type="checkbox"/> Talks constantly                              | <input type="checkbox"/> Rocks self frequently             |
| <input type="checkbox"/> Too impulsive                                 | <input type="checkbox"/> Has difficulty learning new tasks |
| <input type="checkbox"/> Restless                                      | <input type="checkbox"/> Stubborn                          |
| <input type="checkbox"/> Resistant to changes                          | <input type="checkbox"/> Overreacts                        |
| <input type="checkbox"/> Clumsy  | <input type="checkbox"/> Wets bed                          |
| <input type="checkbox"/> Fights frequently                             | <input type="checkbox"/> Frequent temper tantrums          |
| <input type="checkbox"/> Difficulty separating from primary caretakers | <input type="checkbox"/> Nervous habits or tics            |
| <input type="checkbox"/> Falls often                                   |  |

Approximate ages in which your child completed the following routinely:

Held up head (while on stomach): \_\_\_\_\_

Rolled over: \_\_\_\_\_

Belly crawled: \_\_\_\_\_

Crawled on hands and knees: \_\_\_\_\_

Sat independently: \_\_\_\_\_

Pulled to standing: \_\_\_\_\_

Standing independently: \_\_\_\_\_

Walking independently: \_\_\_\_\_

Babbling: \_\_\_\_\_ Were there a variety of sounds: \_\_\_\_\_

Producing single words: \_\_\_\_\_

Combining 2-words: \_\_\_\_\_

Obeying simple commands: \_\_\_\_\_



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Does your child wear orthotics:  Yes  No Type: \_\_\_\_\_

Does your child require/use medical equipment: \_\_\_\_\_

Does your child use assistive devices for walking:  Yes  No Type: \_\_\_\_\_

General impressions of your child's motor development:

Gross Motor:  Slow  Normal  Advanced

Fine Motor:  Slow  Normal  Advanced

Handwriting:  Poor  Fair  Good

Does your child show a hand preference with:

Feeding Which hand: \_\_\_\_\_

Writing/Drawing Which hand: \_\_\_\_\_

Throwing Which hand: \_\_\_\_\_

Pointing Which hand: \_\_\_\_\_

Cutting Which hand: \_\_\_\_\_

Has your child achieved skills and then lost them:  Yes  No

Explain (what and when): \_\_\_\_\_

Has your child received prior therapy? (Please check all that apply):

First Steps  School  Outpatient facility similar to Sensory Solutions

## FEEDING:

Bottle fed:  Yes  No Type of formula: \_\_\_\_\_

Nursed:  Yes  No

Currently eats:

Breast milk

Formula

Baby food

Junior foods

Mashed table foods

Table foods

Feeds self:  All  Most  Some  Rare

If feeds self, uses:  Bottle  Fingers  Spoon  Fork

Drinks from:

Bottle  Sippy cup  Soft straw  Hard straw  Open cup

List most preferred foods: \_\_\_\_\_



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List avoided foods: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SELF-CARE:

Bathes self:  All  Most  Some  None

Undresses self:  All  Most  Some  None

Dresses self:  All  Most  Some  None

Is your child toilet trained:  Yes  No

If yes, at what age: \_\_\_\_\_

Bladder (daytime)  Bladder (day and nighttime)  Bowel

### SENSORY HISTORY:

VESTIBULAR (Movement and gravity information). Check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Rocks while sitting   | <input type="checkbox"/> Jumps a lot                             |
| <input type="checkbox"/> Likes being tossed in the air   | <input type="checkbox"/> Good balance                            |
| <input type="checkbox"/> Fearful of heights  | <input type="checkbox"/> Fearful of movement                     |
| <input type="checkbox"/> Likes Merry-Go-Rounds   | <input type="checkbox"/> Spins and Whirls more than others       |
| <input type="checkbox"/> Gets car sick   | <input type="checkbox"/> Prefers quiet play as opposed to active |
| <input type="checkbox"/> Enjoys being rocked: <input type="checkbox"/> Now <input type="checkbox"/> As an infant |  |
| <input type="checkbox"/> No fear of movement or falling  |  |

Comments: \_\_\_\_\_  
\_\_\_\_\_

TACTILE (Touch information). Check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Avoids messy things (mud, finger paints, etc.) | <input type="checkbox"/> Dislikes face or hands washed            |
| <input type="checkbox"/> Irritated by cloth of certain textures         | <input type="checkbox"/> Objects to being touched                 |
| <input type="checkbox"/> Dislikes unexpected touch                      | <input type="checkbox"/> Avoids using hands for extended periods  |
| <input type="checkbox"/> Bangs head on purpose (now or in past)         | <input type="checkbox"/> Pinches, bites, hurts self               |
| <input type="checkbox"/> Mouths non-food objects                        | <input type="checkbox"/> Feels pain less than others              |
| <input type="checkbox"/> Isolates self from others                      | <input type="checkbox"/> Strong like/dislike toward food textures |
| <input type="checkbox"/> Excessively ticklish                           | <input type="checkbox"/> Dislikes hair washing                    |
| <input type="checkbox"/> Dislikes nail cutting                          | <input type="checkbox"/> Wants to handle everything               |
| <input type="checkbox"/> Seeks a lot of touch                           |   |

Comments: \_\_\_\_\_  
\_\_\_\_\_



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PROPRIOCEPTIVE (Muscle and joint information). Check all that apply:

- Holds hands in strange positions
- Holds body in strange positions
- Good coordination with small items
- Walks on toes (or did when younger)
- Went from sitting to standing with little to no crawling
- Crept on tummy rather than hands and knees
- Leaps from one position to the next, unable to move slowly from one place to another

Comments: \_\_\_\_\_

AUDITORY: (Check all that apply)

- Responds negatively to unexpected or loud noise
- Has difficulty paying attention when there are other noises nearby
- Misses hearing some sounds
- Seems confused as to the direction of sounds
- Seems to enjoy strange noises and/or makes loud noises
- Appears to be hard of hearing
- Enjoys music
- Has a diagnosed hearing loss
- Wears a hearing aid

Comments: \_\_\_\_\_

VISUAL: (Check all that apply)

- Reversals in copying
- Happier in the dark
- Looks very closely at pictures/objects
- Difficulty discriminating shapes or colors
- Resists having eyes covered
- Squints often
- Becomes excited when there is a variety of visual objects
- Difficulty focusing on objects far away
- Difficulty focusing on close objects
- Wears glasses
- Difficulty maintaining eye contact
- Difficulty following objects across the room
- Sometimes shakes head awkwardly
- Difficulty following object tossed to him/her
- Shifts head to one side in order to look at an object

Comments: \_\_\_\_\_

GUSTATORY-OLFACTORY (Taste and smell information). Check all that apply:

- Acts as though all food tastes the same
- Chews on non-food objects
- Has unusual cravings for certain foods
- Dislikes food of certain textures
- Explores by smelling
- Discriminates odor
- Reacts negatively to smell
- Ignores unpleasant odors

Comments: \_\_\_\_\_





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## **SPEECH-LANGUAGE HISTORY:**

SPOKEN LANGUAGE (Expressive Language). Check all that apply:

- Makes no sounds or makes sounds on a limited basis
- Uses gestures more than words to communicate
- Babbles only
- No true words
- Uses sign language. If yes, what signs: \_\_\_\_\_
- Produces only single words or short phrases
- Produces simple sentences
- Produces long sentences
- Produces long sentences which are disorganized or hard to understand what the child means
- Repeats words often or hesitates frequently
- Words are difficult to understand (articulation)
- Voice quality is unusual (e.g., hoarse, nasal, abnormally high pitched)
- Has difficulty recalling recent events
- Has trouble remembering the correct names of items or people
- Has no apparent problems expressing himself/herself
- Seems frustrated when attempting to relate events
- Stutters frequently

Approximately how many words does your child produce spontaneously: \_\_\_\_\_

Comments on any of the above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

COMPREHENSION (Receptive Language). Check all that apply:

- Does not understand spoken language
- Understands a few words
- Understands most words
- Understands simple conversations
- Understands everything said to him/her
- Follows simple commands
- Requires directions to be broken down in steps in order to follow
- Follows all directions easily

Comment on any of the above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PRAGMATIC LANGUAGE (Social Skills). Check all that apply:

- Difficulty interacting with peers and/or adults
- Difficulty greeting/saying goodbye to others



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- Difficulty with turn-taking
- Difficulty with maintaining conversations
- Makes frequent inappropriate remarks
- Difficulty making/maintaining eye contact

Comment on any of the above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### ARTICULATION (Check all that apply):

- Speech sounds are not understood by others
- Speech sounds are understood by others some of the time
- Speech sounds are understood by others most of the time
- Speech sounds are understood by others all of the time

Comment on any of the above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If applicable, how severe do you think your child's language and/or articulation is:

- Severe
- Moderate
- Mild

Is your child aware of the problem:  Yes  No

How does he/she react: \_\_\_\_\_

Is any language other than English used in the home:  Yes  No

If yes, what language(s): \_\_\_\_\_

What percent of the time: \_\_\_\_\_

### SCHOOL INFORMATION:

School: \_\_\_\_\_ Grade: \_\_\_\_\_

School Days:  Part day (AM/PM)  All day

Teacher: \_\_\_\_\_

Grades Repeated: \_\_\_\_\_ Grades Skipped: \_\_\_\_\_

Has your child been in a special classroom and/or attended any remedial classes:  Yes  No

If yes, describe what type, when, and when: \_\_\_\_\_

Does your child have an IEP/IFSP:  Yes  No

If yes, please provide a copy to your therapist

Have you or the teacher observed that you child is (Check all that apply):

- Noticeably distracted in class
- Functions better in a one-to-one relationship rather than in classroom situations
- Has to be reminded how to hold pencil/paper when writing
- Needs to prop his/her head in hand while reading or writing at the desk



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\_\_ Confused in right-left discrimination tasks (describe): \_\_\_\_\_

\_\_ A poor speller

Which academic skills are the hardest: \_\_\_\_\_

If there are other concerns not covered in this form, please share: \_\_\_\_\_

\_\_\_\_\_

Person completing this form: \_\_\_\_\_

Date: \_\_\_\_\_

V-05-216

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