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?:_____

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:_____
_____

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			
Opthamologist/ 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:
__Usually happy
__Mostly quiet
__Overly active
__Tires easily
__Talks constantly
__Too impulsive
__Restless
__Resistant to changes
__Clumsy
__Fights frequently
__Difficulty separating from primary caretakers
__Falls often
__Poor attention span
__Easily frustrated
__Cries often
__Cries infrequently
__Rocks self frequently
__Has difficulty learning new tasks
__Stubborn
__Overreacts
__Wets bed
__Frequent temper tantrums
__Nervous habits or tics

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:_____

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:_____

_____
_____

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:
__Rocks while sitting
__Likes being tossed in the air
__Fearful of heights
__Likes Merry-Go-Rounds
__Gets car sick
__Enjoys being rocked: __Now __As an infant
__No fear of movement or falling
__Jumps a lot
__Good balance
__Fearful of movement
__Spins and Whirls more than others
__Prefers quiet play as opposed to active
Comments:_____
_____

TACTILE (Touch information). Check all that apply:
__Avoids messy things (mud, finger paints, etc.)
__Irritated by cloth of certain textures
__Dislikes unexpected touch
__Bangs head on purpose (now or in past)
__Mouths non-food objects
__Isolates self from others
__Excessively ticklish
__Dislikes nail cutting
__Seeks a lot of touch
__Dislikes face or hands washed
__Objects to being touched
__Avoids using hands for extended periods
__Pinches, bites, hurts self
__Feels pain less than others
__Strong like/dislike toward food textures
__Dislikes hair washing
__Wants to handle everything
Comments:_____
_____

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:_____
_____

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

__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

__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:_____

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