



# Sensory Solutions, LLC

Physical, Speech, Occupational, and Nutritional Health Therapy for Children

## Patient History Form

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

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Person Completing this Form and relationship: \_\_\_\_\_

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

Diagnosis(es) (i.e., Autism, Down syndrome, ADHD, etc.) \_\_\_\_\_

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

\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Relationship to Child:  Biological  Foster  Adoptive  Other: \_\_\_\_\_

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

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

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

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

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

Parent/Guardian Name: \_\_\_\_\_

Relationship to Child:  Biological  Foster  Adoptive  Other: \_\_\_\_\_

Address \_\_\_\_\_

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

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

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

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

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

Emergency contact information:

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

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

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

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



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

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

### MEDICAL HISTORY:

Pregnancy:  Full Term  Premature

Length of Pregnancy: \_\_\_\_\_ (weeks or months)

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

\_\_\_\_\_

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

Labor/Delivery Complications:

Induced Birth

Breech Presentation

Limpness

Stiffness

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

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

\_\_\_\_\_

Delivery Type:

Vaginal

C-section

Complications following birth regarding child:

Jaundice

Cyanosis

Congenital defects

Other (please specify): \_\_\_\_\_

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



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Did your baby require any of the following:

Oxygen      How long: \_\_\_\_\_  
 Transfusions      Type(s): \_\_\_\_\_  
 Tube Feedings      Type(s) and how long: \_\_\_\_\_  
 Other (please specify): \_\_\_\_\_

Were there any feeding difficulties at birth:  Yes  No

Please specify feeding difficulties at birth: \_\_\_\_\_

List illnesses/diseases/injuries/operations your child has experienced:

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

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: \_\_\_\_\_



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History of acid reflux: \_\_\_ Yes \_\_\_ No

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

Is your child currently taking any medications/vitamins/supplements: \_\_\_ Yes \_\_\_ No

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

## SPECIALTY SERVICES YOUR CHILD RECEIVES:

Audiologist       Behavior Therapist       Cardiologist       Chiropractor  
 Dietitian       ENT       Neurologist       Occupational Therapist  
 Ophthalmologist       Optometrist       Orthopedist       Physical Therapist  
 Psychologist       Psychiatrist       Speech Pathologist       GI  
 Other (please specify): \_\_\_\_\_

## DEVELOPMENTAL HISTORY:

### Developmental Milestones:

Approximate ages in which your child completed the following routinely:

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

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

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

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

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

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

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

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

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

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

Combining two words: \_\_\_\_\_

Obedying simple commands: \_\_\_\_\_

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

Fussy

Irritable

Good

Quiet

Liked being held

Resisted being held

Floppy when held

Tense muscles when held



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Passive  
 Active

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                                   |  |

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:

- |  |                   |
|--|-------------------|
| <input type="checkbox"/> Feeding         | Which hand: _____ |
| <input type="checkbox"/> Writing/Drawing | Which hand: _____ |
| <input type="checkbox"/> Throwing        | Which hand: _____ |
| <input type="checkbox"/> Pointing        | Which hand: _____ |
| <input type="checkbox"/> Cutting         | Which hand: _____ |

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

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



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## FEEDING:

Is your child a selective/picky eater:  Yes  No

Is your child able to use utensils independently:  Yes  No

## SELF-CARE:

Bathes self:  Independently  Needs Assistance

Undresses self:  Independently  Needs Assistance

Dresses self:  Independently  Needs Assistance

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

Jumps a lot

Likes being tossed in the air

Good balance

Fearful of heights

Fearful of movement

Likes Merry-Go-Rounds

Spins and Whirls more than others

Gets car sick

Prefers quiet play as opposed to active

Enjoys being rocked:  Now  As an infant

No fear of movement or falling

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

TACTILE (Touch information). Check all that apply:

Avoids messy things (mud, finger paints, etc.)

Dislikes face or hands washed

Irritated by cloth of certain textures

Objects to being touched

Dislikes unexpected touch

Avoids using hands for extended periods

Bangs head on purpose (now or in past)

Pinches, bites, hurts self

Mouths non-food objects

Feels pain less than others

Isolates self from others

Strong like/dislike toward food textures

Excessively ticklish

Dislikes hair washing

Dislikes nail cutting

Wants to handle everything

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

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 235 Dunn Rd.  
 Florissant, MO 63031  
 314.912.4707  
 Fax 314.866.5849

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**sensorysolutions.org**



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Explores by smelling

Discriminates odor

Reacts negatively to smell

Ignores unpleasant odors

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

## **SPEECH-LANGUAGE HISTORY CONCERNS (CHECK ALL THAT APPLY):**

Spoken Language/Expressive Language

Comprehension/Receptive Language

Articulation/Speech Sound Production

Stuttering

Social Skills

Other (please specify): \_\_\_\_\_

## **SCHOOL/DAYCARE/THERAPY INFORMATION:**

Does your child attend school/daycare:  Yes  No

School/Daycare: \_\_\_\_\_ Grade: \_\_\_\_\_

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

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

Has the teacher expressed any concerns  Yes  No

(If yes, please specify): \_\_\_\_\_

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

First Steps  School  Outpatient facility similar to Sensory Solutions

Does your child have an IEP/IFSP/504 Plan:  Yes  No

If yes, please provide a copy to your therapist

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

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

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