Pediatric Therapy of Riverside

Date submitted: _____

Patient

First Name		Last Name	
Birthdate		Gender	

Parent

First Name		Last Name	
E-mail		Phone	
Home Address			

Emergency contact

First Name		Last Name	
E-mail		Phone	
Relationship			

Pediatrician

First Name		Last Name	
Office Address			
Office Phone			

School

School Name			
Teacher		Grade	

Please indicate your primary concerns.

What goals do you have for your child's therapy?

At what age did you first become concerned? _____

Is your child being seen by a specialist? [ ] yes [ ] no
If yes, what type and by who? _____

Does your child have a current IEP for school therapy? [ ] yes [ ] no

Is your child in a self-contained classroom? [ ] yes [ ] no

What services does your child receive at school?

Has your child ever been seen by another therapist? Please list therapist, therapy and dates of therapy:

Medical History

Birth history, including complications during pregnancy, labor, and delivery:

Is your child adopted? [ ] yes [ ] no

List any hospitalizations including date and issue:

List any pre-existing diagnoses, including medical conditions:

List any equipment your child uses regularly:

List all medications:

List any feeding issues: (Picky eater, self-feeding, oral motor)

List all allergies or special diet restrictions:

Immunizations up to date? [ ] yes [ ] no

Speech/Language

Do others understand your child? [ ] yes [ ] no

Does your child understand you? (ex: able to follow directions) [ ] yes [ ] no

Do you have concerns about your child's hearing? [ ] yes [ ] no

Has your child's hearing been tested? [ ] yes [ ] no

Hearing test location: _____

Hearing test date: _____

Hearing test result: _____

Is another language spoken at home other than English? [ ] yes, _____ [ ] no

List any family history of speech disorder: _____

Developmental History

List age at which developmental milestones were achieved:

Babbled:

Spoke first words:

List first words spoken:

Rolled Over:

Sat Alone:

Crawled:

Stood Alone:

Walked alone:

Self-fed w/ spoon:

Toilet Trained:

Please indicate if your child used or uses the following:

Pacifier:

Thumb/finger sucking:

Bottle:

Sippy Cup:

Open Cup:

Utensils:

Please rate the development of your child's motor and self-help skills:

Gross Motor (jumping, stairs, ball skills, etc.)	[ ] Poor	[ ]Fair	[ ] Age-appropriate
Fine Motor (grasp, pincer, drawing, scissors)	[ ] Poor	[ ]Fair	[ ] Age-appropriate
Self-help (i.e. dressing, feeding self)	[ ] Poor	[ ]Fair	[ ] Age-appropriate

Please list any specific concerns you have about your child's motor skills?

Is your child a picky eater, especially regarding food textures? [ ] yes [ ] no

Does your child avoid messy play? [ ] yes [ ] no

Does your child respond negatively to unexpected or loud noises? [ ] yes [ ] no

Does your child hold hands over ears to protect them from sound? [ ] yes [ ] no

Does your child enjoy strange noises or seek to make noise often? [ ] yes [ ] no

Does your child seek movements that interfere with daily routines? [ ] yes [ ] no

Does your child have difficulty paying attention? [ ] yes [ ] no

Does your child get along with other children? [ ] yes [ ] no

What are your child's favorite activities, toys, characters from books, TV, movies, etc.?

What do you consider to be your child's strengths?

What do you consider to be your child's weaknesses?

Additional Concerns:

Parent Signature: _____