Child's Play Therapy Center

General Information					
Child's name:				Date of Birth:	
Address:	City:		State: AL	Zip:	
Phone: (best contact number): - -		Email:			
Parent(s)/Guardian(s):					
Referred By:			Phone: - -		
Physician:			Phone: - -		
Brothers & Sisters (names, ages):	1: Age:	2: Age:	3: Age:		
4: Age:	5: Age:	6: Age:	7: Age:		
Mother's occupation:					
Father's occupation:					
What goals would you like to see achieved through speech therapy, occupational therapy or physical therapy services?					
What are your child's hobbies and favorite interests?					
Please provide any additional information that you believe would help the therapist get to know your child:					

Prenatal and Birth History					
Adopted:	Yes: ☐	No: ☐			
If yes, please list any factors that may have contributed to your child's development:					
Mother's general health during pregnancy (illnesses, accidents, medications, etc.):					
Select type of delivery:	Head First: ☐	Feet First: ☐	Breech: ☐	Caesarian: ☐	
Were there any unusual conditions that may have affected the pregnancy or birth?			Yes: ☐	No: ☐	
Was the delivery premature?	Yes: ☐	No: ☐	If yes, how many weeks?		

Medical History					
Provide the approximate(age) the child suffered the following illnesses and Conditions:					
Draining Ear:	Seizures:	Ear Infections:	Asthma:	High Fever:	Other:
Has the child had any surgeries?		Yes: ☐	No: ☐		
If yes, what type and when (e.g., Tonsillectomy, Adenoidectomy, etc.)?					
What were the results?					
Describe any major accidents or hospitalizations:					
Has your child had a vision exam?		Yes: ☐	No: ☐		
(If yes, what were the results?)					
Has your child had a hearing exam?		Yes: ☐	No: ☐		
If yes, what were the results?)					
Is your child currently taking any medications?		Yes: ☐	No: ☐		
Does your child have any allergies?		Yes: ☐	No: ☐		

Developmental History				
At what age did your child achieve the following milestones? Some of the milestones may not be applicable to your child at this time.				
Milestone	**Age**	**Milestone**	**Age**	
Hold head up		Spoon feed independently		
Roll over		Tying shoes		
Sit independently		Toilet trained		
Crawl on hands and knees		Use single words (e.g., *no, mom, doggie*, etc.)		

Cruise around furniture		Combine words (e.g., *me go, daddy shoe*, etc.)	
Walk independently		Name simple objects (e.g., *dog, car, tree*, etc.)	
Drink from an open cup		Use simple questions (e.g., *Where's doggie?* etc.)	
Eat solid food		Engage in a conversation	

Educational History			
School:			
Grade:			
Teacher(s):	1:	2:	3:

	Yes	No
Does the child receive special services? If yes, describe:	☐	☐
How does the child interact with others (e.g., shy, aggressive, uncooperative, etc.)?		
Have any other specialists (physicians, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions:	☐	☐

Activities of Daily Living	**(Check if no concerns in this area): N/A:** ☐		
Is your child able to perform the following self-help skills?			
Dresses self:	☐	Drinks from an open cup:	☐
Undresses self:	☐	Zippers:	☐
Toileting :	☐	Zippers:	☐
Brushes teeth:	☐	Snaps :	☐
Washes hands:	☐	Puts on shoes:	☐
Feeds self:	☐	Puts on socks:	☐
Drinks from an open cup:	☐	Ties shoes:	☐

Sensory History	**(Check if no concerns in this area): N/A:** ☐	Yes	No
Does your child become upset when getting messy or dirty (e.g., dirt, glue, finger painting, etc)?		☐	☐
Does your child seem to crave jumping or falling into objects or people?		☐	☐
Does your child become upset when hearing an unexpected or loud sound?		☐	☐
Does your child have difficulty discriminating between the size and shape of an object?		☐	☐
Does your child seem overly cautious on playground equipment?		☐	☐

Gross Motor Skills/Motor Planning	**(Check if no concerns in this area): N/A:** ☐				
Is your child able to…?	Yes	No		Yes	No
Hop/balance on one foot?	☐	☐	Jump rope?	☐	☐
Skip?	☐	☐	Kick a ball?	☐	☐
Climb on or over objects?	☐	☐	Throw/catch a ball?	☐	☐
Jump with both feet together?	☐	☐	Dribble a ball?	☐	☐
Ride a tricycle?	☐	☐	Pump self on a swing?	☐	☐
Ride a bicycle without training wheels?	☐	☐	Ascend and descend stairs?	☐	☐
Does your child…					
Have slow and deliberate movements with motor activities?	☐	☐			
Move quickly and lose control?	☐	☐			
Seem uncoordinated or awkward?	☐	☐			
Have difficulty running?	☐	☐			
Have difficulty learning new skills?	☐	☐			

Fine Motor Skills (Check if no concerns in this area): N/A: ☐					
Is your child able to…?	Yes	No	**Does your child…**	Yes	No
Cut with scissors?	☐	☐	Have difficulty holding a pencil correctly?	☐	☐
Color inside the lines?	☐	☐	Reverse letters when writing?	☐	☐
Play with manipulative toys?	☐	☐	Have difficulty with spacing and sizing of letters?	☐	☐
Demonstrate a consistent hand preference?	☐	☐	Express fatigue when writing?	☐	☐
Identify left and right hands?	☐	☐	Become easily frustrated when writing?	☐	☐
			Have difficulty copying shapes?	☐	☐
			Have difficulty remaining on a line when writing?	☐	☐

Feeding/Oral Motor (Check if no concerns in this area): N/A: ☐		
	Yes	No
Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, choking, drooling, chewing, etc.)?	☐	☐
If yes, please describe:		
Have there ever been any concerns with the intake of liquids (e.g., choking, aspiration)?	☐	☐
Are your child's food preferences a concern?	☐	☐
Does your child prefer certain textures (e.g., crunchy, soft, chewy, etc.) or flavors (e.g., sweet, salty, sour, etc.) of food?	☐	☐
What are some of the typical foods in your child's diet?	☐	☐
Does your child gag when eating certain foods or textures?	☐	☐
Does your child chew on non-food objects?	☐	☐
Does your child use a pacifier or suck their thumb?	☐	☐
Does your child become upset with their teeth being brushed?	☐	☐
Does your child require a special diet?	☐	☐
Does your child have a history of reflux?	☐	☐

Speech/Language (Check if no concerns in this area): N/A: ☐		
Describe the child's speech-language problem:		
How does the child usually communicate (gestures, single words, short phrases, sentences)?		
Have any other speech-language specialists seen the child?	Yes: ☐	No: ☐
If yes, Who and when?		
What were their conclusions or suggestions?		
Are there any other speech, language, or hearing problems in your family?	Yes: ☐	No: ☐
If yes, please describe:		

Person completing form:	
Relationship to child:	
Signed:	Date: