made2move:therapy4kids

062013

Child History Form

Please complete the following information prior to your child's scheduled evaluation. This information is used as part of the initial assessment.

Name: _____ **DOB:** _____

Address: _____

Parent: _____ Phone: _____

Please indicate your concerns (the reason for the evaluation) and provide brief description:

☐ Fine motor _____ ☐ Handwriting _____
☐ Sensory _____ ☐ Movement _____
☐ Mobility _____ ☐ Coordination _____
☐ Transitions _____ ☐ Play _____
☐ Speech _____ ☐ Language _____
☐ Feeding _____ ☐ Swallowing _____
☐ Behavior _____ ☐ Visual processing/motor _____
☐ Activities of Daily living (dressing, bathing, chores) _____

Medical Diagnosis: _____ **by whom?** _____

Therapy(ies) requested? ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech

Allergies: Please specify allergic reaction and severity (latex, food - peanut butter, eggs, dairy, etc)
☐NKA ☐Allergies to: _____
Reaction: _____

Therapy Precautions:

- Are there any movement restrictions ☐ **NO** ☐ **YES** specify: _____
- Are there any dietary restrictions? ☐ **NO** ☐ **YES** specify: _____
- Does your child require equipment? ☐ **NO** ☐ **YES** specify: _____
  ☐**AFOS** right left both ☐**Hand braces** right left both ☐ **VOCA**
  ☐ **Walker** ☐ **Wheelchair** manual power Age of equipment: _____
  Company: _____ **Phone:** _____
- **Does your child have a shunt?** ☐ **NO** ☐ **YES** revision date: _____
- Is your child taking any medications? ☐ **NO** ☐ **YES** specify: _____
- Has your child been diagnosed with Down Syndrome? ☐ **NO** ☐ **YES**
  - Has the doctor indicated Atlantoaxial instability? ☐ **NO** ☐ **YES**
  - Are there restrictions? ☐ **NO** ☐ **YES** specify: _____

Parent signature: _____ Date: _____

11343 N Sam Houston Parkway East Humble, TX 77396
713- 254-5541 FAX 281-441-9081
www.made2movetherapy4kids.com