

5. Please list the child's siblings (Age, Medical Problems, Social, & School Problems)

B. Development

Please fill in any information you have on the areas listed below.

Pregnancy and delivery

Any prenatal (before birth) problems?

Was the child premature? _____ Weight and height at birth: _____

Any birth complications or problems?

The first few months of life

Breast-fed? Yes No If so, for how long? _____

Any allergies? Yes No

Please list any problems during infancy

During this child's first three years, were any special problems noted in the following areas?

- | | | |
|---|--|---|
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Excessive crying | <input type="checkbox"/> Withdrawn behavior |
| <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Early learning problems | <input type="checkbox"/> Destructive behavior |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Twitching | <input type="checkbox"/> Unable to separate from parent |
| <input type="checkbox"/> Other: _____ | | |

Milestones: At what age did this child do each of these?

Sit without support: _____ Crawl: _____
Walk without holding on: _____ Help when being dressed: _____
Eat with a fork: _____ Stay dry all day: _____
Didn't soil his/her pants: _____ Stay dry all night: _____
Dress self completely: _____

Can the child be described as clumsy/uncoordinated? Yes No
 Having fine motor delay? Yes No
 Which hand does your child use for:
 Writing/drawing? _____ Eating? _____ Cutting? _____
 Current eating behavior: Normal Picky Eats too much Weight loss/gain
 Oral Motor concerns: None Difficulty swallowing Drooling Gagging

Speech/language development

Age when child said first word understandable to strangers:

Age when child said first sentence understandable to strangers:

Any speech, hearing, or language difficulties?

Has there ever been a regression in the adolescent's speech? Yes No
 If yes, please explain: _____

Checklist: Please mark any of the following in each area that describe your child currently or in the past:

Speech

Past	Current		Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	slow speech development	<input type="checkbox"/>	<input type="checkbox"/>	doesn't understand without gestures
<input type="checkbox"/>	<input type="checkbox"/>	unusual tone or pitch	<input type="checkbox"/>	<input type="checkbox"/>	repeats words/phrases over and over
<input type="checkbox"/>	<input type="checkbox"/>	difficult to understand speech	<input type="checkbox"/>	<input type="checkbox"/>	repeats questions, instead of answering them
<input type="checkbox"/>	<input type="checkbox"/>	seldom speaks unless prompted	<input type="checkbox"/>	<input type="checkbox"/>	repeats dialogue from movies/songs verbatim
<input type="checkbox"/>	<input type="checkbox"/>	speaks in a concrete/literal form			
<input type="checkbox"/>	<input type="checkbox"/>	doesn't understand idioms/ figures of speech			
<input type="checkbox"/>	<input type="checkbox"/>	has language of his/her own (may sound like foreign language/jargon)			

Relating with other people

Past	Current		Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	prefers to be by self	<input type="checkbox"/>	<input type="checkbox"/>	"in a world of his/her own"
<input type="checkbox"/>	<input type="checkbox"/>	aloof, distant	<input type="checkbox"/>	<input type="checkbox"/>	clings to people
<input type="checkbox"/>	<input type="checkbox"/>	fearful of strangers	<input type="checkbox"/>	<input type="checkbox"/>	not cuddly as baby
<input type="checkbox"/>	<input type="checkbox"/>	doesn't like to be held	<input type="checkbox"/>	<input type="checkbox"/>	doesn't recognize parent
<input type="checkbox"/>	<input type="checkbox"/>	doesn't play with other children			
<input type="checkbox"/>	<input type="checkbox"/>	prefers playing with younger or older children			

Imitation

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation)
<input type="checkbox"/>	<input type="checkbox"/>	doesn't repeat words/things said to him
<input type="checkbox"/>	<input type="checkbox"/>	doesn't repeat words generally, but usually did what he was asked to do

Response to Sounds, Speech

- | Past | Current | | Past | Current | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | often ignores sounds | <input type="checkbox"/> | <input type="checkbox"/> | often ignores what is said to him/her |
| <input type="checkbox"/> | <input type="checkbox"/> | afraid of certain sounds | <input type="checkbox"/> | <input type="checkbox"/> | really likes certain sounds (music, motors, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | doesn't respond/orient to name | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | seems to hear distant or soft sounds that most other people don't hear or notice | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | unpredictable response to sounds (sometimes reacts, sometimes doesn't) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | responds to speech and sounds like other children of the same age | | | |

Visual Response

- | Past | Current | | Past | Current | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | stares vacantly around room | <input type="checkbox"/> | <input type="checkbox"/> | plays with turning lights on and off |
| <input type="checkbox"/> | <input type="checkbox"/> | often doesn't look at things | <input type="checkbox"/> | <input type="checkbox"/> | distracted by lights – stares at certain lights |
| <input type="checkbox"/> | <input type="checkbox"/> | likes to look at self in mirror | <input type="checkbox"/> | <input type="checkbox"/> | very interested in small parts of an object |
| <input type="checkbox"/> | <input type="checkbox"/> | likes to look at shiny objects | <input type="checkbox"/> | <input type="checkbox"/> | looks at things out of the corners of eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | stares at parts of his/her body (e.g. hands) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | often avoids looking at people when they are talking to him | | | |

Other Senses

- | Past | Current | | Past | Current | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | puts many objects in mouth | <input type="checkbox"/> | <input type="checkbox"/> | likes vibrations |
| <input type="checkbox"/> | <input type="checkbox"/> | licks objects | <input type="checkbox"/> | <input type="checkbox"/> | doesn't notice pain as much as most people |
| <input type="checkbox"/> | <input type="checkbox"/> | overreacts to pain | <input type="checkbox"/> | <input type="checkbox"/> | smells objects unusual or unfamiliar objects |
| <input type="checkbox"/> | <input type="checkbox"/> | chews or eats objects that are not supposed to be eaten | | | |

Emotional Responses

- | Past | Current | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | temper tantrums |
| <input type="checkbox"/> | <input type="checkbox"/> | laughs/smiles for no obvious reason |
| <input type="checkbox"/> | <input type="checkbox"/> | overly responds to situations |
| <input type="checkbox"/> | <input type="checkbox"/> | moods change quickly/for no apparent reason |
| <input type="checkbox"/> | <input type="checkbox"/> | cries/seems sad for no obvious reason |
| <input type="checkbox"/> | <input type="checkbox"/> | often has blank expression on face |
| <input type="checkbox"/> | <input type="checkbox"/> | little response to what is happening around him/her |

Adaptive Skills:

- | | | |
|---|--|--|
| Feeds self | <input type="checkbox"/> No | <input type="checkbox"/> Yes, beginning at age _____ |
| Dresses self | <input type="checkbox"/> No | <input type="checkbox"/> Yes, beginning at age _____ |
| Bathes self | <input type="checkbox"/> No | <input type="checkbox"/> Yes, beginning at age _____ |
| Helps with household chores | <input type="checkbox"/> No | <input type="checkbox"/> Yes, beginning at age _____ |
| Knows first and last name | <input type="checkbox"/> No | <input type="checkbox"/> Yes, beginning at age _____ |
| Says "please" and "thank you" | <input type="checkbox"/> No | <input type="checkbox"/> Yes, beginning at age _____ |
| Able to walk up/down stairs | <input type="checkbox"/> No | <input type="checkbox"/> Yes, beginning at age _____ |
| Has the child ever lost skills, which at one time he/she was able to perform? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, please explain: | _____ | |

C. Health

List all past illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition:	Age:	Treatment?	Consequences?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all **current** medications the child is taking.

Name of medication:	Dosage prescribed:	How many times per day:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list **past** medications child has taken previously.

D. Behavior

Please list any concerns you have about your child's behavior.

How does your child get along with peers?

How does your child get along with siblings?

Are there any stressful events occurring in the family that may be affecting your child?

Does your child have problems with aggression, self-injury, destruction of items, elopement?

To your knowledge, has your child ever been abused or neglected?

Is there anyone in the child's family that has ever had: Family member(s):

Learning Difficulties _____

Attentional Problems _____

Emotional Difficulties _____

Diagnosed Disorder(s) _____

Alcohol or Drug problems, _____

Their own history of abuse _____

Please list any **current** intervention your child is receiving (Speech, OT, PT, psychotherapy).

From/To	Description of treatment	Provider	Diagnosis
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Please list any **past** treatment for your child (Speech, OT, PT, psychotherapy).

From/To	Description of treatment	Provider	Diagnosis
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Please list any past **evaluations** for your child (Speech, OT, PT, Psychological), and the provider's name

E. Schools/Learning

Please list all schools child has attended beginning with school they are enrolled in at present:

Has your child ever had difficulty adjusting to school (i.e. staying on task, understanding and following instructions, interacting well with other children)?

Does your child currently receive any special education services? Yes No

If so, what is your child's classification

How often does your child receive services?

Has your child ever received any special services in the past?

Does (did) your child have any problems learning letters/numbers?

Does he/she confuse the sounds in words when speaking?

Can your child rhyme words?

Describe his/her handwriting. Is it a problem?

Can your child follow one step directions? Two step directions?

Does your child appear to use vocabulary that is age-appropriate?

Describe his/her oral expression (uses 1-2 words, full sentences) :

READING			WRITTEN EXPRESSION			MATHEMATICS		
	Yes	No		Yes	No		Yes	No
Decoding			Handwriting			Math Fact		
Fluency			Spelling			Numerical		
Comprehension			Expository Composition			Math Problem		

Behavior questions:

Does your child...

1. Cuddle like other children:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Look at you when you are talking or playing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Smile in response to a smile from others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Engage in reciprocal, back-and-forth play?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Play simple imitation games, such as pat-a-cake or peek-a boo?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Show interest in others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Point with his or her finger?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Gesture (e.g., nod yes and no)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Direct your attention by holding up objects for you to see?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Show things to people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Give inconsistent response to his or her name (or to commands)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Use rote, repetitive, or echolalic speech?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Memorize strings of words or scripts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Have repetitive, stereotyped, or odd motor behavior?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Have preoccupations or a narrow range of interests?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Attend more to parts of an object (e.g., the wheels of a toy car)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Have limited or absent pretend play?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Imitate other people's actions (e.g. wave bye-bye, play patty cake?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Play with toys in the same exact way every time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Appear strongly attached to a specific unusual object(s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child seem sensitive to....		
1. Touch (tags, clothing, touch by others)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Noise (puts hands over hears, becomes very distracted)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Foods (textures, tastes, temperatures)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Smells (highly sensitive to faint smells or smells objects)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Movement (does not like swings, somersaults, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Changes in routine (cannot transition, becomes upset)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Activity (tires easily, props self when playing/sitting)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list your child's play interests, toy preferences, and any special talents.

What things do you and your child enjoy doing together?

What reports/information have you gotten from parent/teacher conferences about your child?

