Today's Date _____ Form is completed by ☐ Parent ☐ Guardian (please check one)

Client's Name _____ Date of Birth _____

Address _____ Phone Home _____

City _____ Work _____

State _____ Zip _____

Country _____ Email _____

Mailing Address (if different from above) _____

Client lives with ☐ Parent ☐ Guardian ☐ Other _____

Mother's Name _____ Date of Birth _____

Address _____ Phone Home _____

City _____ Work _____

State _____ Zip _____ Cell _____

Education Completed _____ Occupation _____

Father's Name _____ Date of Birth _____

Address _____ Phone Home _____

City _____ Work _____

State _____ Zip _____ Cell _____

Education Completed _____ Occupation _____

Guardian's Name _____ Date of Birth _____

Address _____ Phone Home _____

City _____ Work _____

State _____ Zip _____ Cell _____

Education Completed _____ Occupation _____

1. CHILD INFORMATION

Siblings

Name _____ **Age** _____ **Name** _____ **Age** _____

Name _____ **Age** _____ **Name** _____ **Age** _____

Name _____ **Age** _____ **Name** _____ **Age** _____

2. MEDICAL HISTORY

Family Physician _____ **Phone Number** _____

Address _____

Client's birth weight _____ **lbs** _____ **oz** **Length of pregnancy** _____

Complications during pregnancy and/or delivery? ☐ **Yes** ☐ **No** **If yes, please describe** _____

_____

_____

Has the client ever had a head brain injury? ☐ **Yes** ☐ **No** **If yes, please describe** _____

_____

_____ **Date(s)** _____

Pertinent medical, neurological, visual, hearing, therapeutic, psychological, or educational testing:

Date	Examined by	Diagnosis	Recommendations

Surgeries? ☐ Yes ☐ No Please Describe _____

_____

Seizures? ☐ Yes ☐ No Frequency of Seizures _____ Length _____

Type(s) _____

Currently taking seizure medications? ☐ Yes ☐ No List medication(s)_____

Seizure medications taken previously? ☐ Yes ☐ No List medication(s)_____

Currently taking other medications? ☐ Yes ☐ No List medication(s)_____

_____

Are there any medical problems which place limitations on physical activity, etc? ☐ Yes ☐ No

List _____

_____

Broken limbs? ☐ Yes ☐ No List specifics _____

3. Health

Was the client nursed? ☐ Yes ☐ No If yes, until what age? _____

Describe the client's diet _____

_____

List dietary supplements and vitamins

_____

_____

_____

_____

_____

_____

_____

	Excessive	Daily	Weekly	Rarely	Never
Vegetables	☐	☐	☐	☐	☐
Fruit	☐	☐	☐	☐	☐
Meat	☐	☐	☐	☐	☐
Sugar	☐	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐	☐
Artificial Coloring	☐	☐	☐	☐	☐
Dairy Products	☐	☐	☐	☐	☐
White Flour	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐

Food allergies? ☐ Yes ☐ No ☐ Never Tested

_____ _____

_____ _____

_____ _____

Food Cravings? ☐ Yes ☐ No

Picky eater? ☐ Yes ☐ No

Overeats? ☐ Yes ☐ No

Poor appetite? ☐ Yes ☐ No

Allergies? ☐ Yes ☐ No If yes, please describe _____

_____

Does the client have a history of cold or sinus congestion? ☐ Yes ☐ No

Does the client have a history of ear infections? ☐ Yes ☐ No

If yes, which ears have been affected? ☐ Left ☐ Right ☐ Both

How many? _____ Over what period of time? _____

Does the client have Tinnitus (ringing in the ear)? ☐ Yes ☐ No

If yes, which ears have been affected? ☐ Left ☐ Right ☐ Both

Is the Tinnitus ☐ Continuous ☐ Intermittent

Does the client have hearing loss? ☐ Yes ☐ No

If yes, which ears have been affected? ☐ Left ☐ Right ☐ Both

Degree of hearing loss _____

Does the client have hypersensitive hearing? ☐ Yes ☐ No

If yes, was it treated with sound therapy? ☐ Yes ☐ No

If yes, what was implemented _____

Has the client had a tympanogram, audiogram, ABR? ☐ Yes ☐ No

If yes, what were the results _____

Has the client had an eye examination? ☐ Yes ☐ No

Does the client wear glasses or contact lenses? ☐ Yes ☐ No

If yes, what is the prescription _____

Has the client been diagnosed with any of the following: (please check)

☐ Near Sighted	☐ Far Sighted	☐ Astigmatism	☐ Amblyopia
☐ Stabismus	☐ Macular Problems	☐ Glaucoma	☐ Cataracts
☐ Nystagmus	☐ Blind	☐ Cortical Blindness	☐ Other

Sleep times: From _____ **To** _____ **Naps: From** _____ **To** _____

Client physical activity level

Daily? ☐ **Yes** ☐ **No** **How many days per week** _____

Types of activities _____

Duration of activities _____

Please check services currently being utilized:

☐ Neurologist	☐ Chiropractor	☐ Music Therapist
☐ Psychiatrist	☐ Tutor	☐ AIT, Sound Therapist
☐ Psychologist	☐ Occupational Therapist	☐ Counselor
☐ Orthopedist	☐ Physical Therapist	☐ Cardiologist
☐ Speech Therapist	☐ Osteopathic Physician	☐ EEG Neurofeedback Therapy
☐ Naturopathic Physician	☐ Vision Therapist	

☐ **Other** _____

If being seen on a weekly basis, how many times/sessions a week? _____

Other health problems? ☐ **Yes** ☐ **No** **List** _____

_____

4. BEHAVIOR

Does the client have a history of emotional or behavioral disorders? ☐ **Yes** ☐ **No**

Please describe _____

Is there a family history of emotional or behavioral disorders? ☐ **Yes** ☐ **No**

Please describe _____

Client's specific positive behaviors _____

Client's specific negative behaviors _____

Do you have specific behavioral goals for the client? ☐ Yes ☐ No

Please describe _____

	Yes	No	Not Sure		Yes	No	Not Sure
Distractible	☐	☐	☐	Difficulty Following Directions	☐	☐	☐
Short Attention Span	☐	☐	☐	Difficulty with Parents	☐	☐	☐
Hyperactive	☐	☐	☐	Difficulty with Siblings	☐	☐	☐
Hypoactive (low activity level)	☐	☐	☐	Difficulty with Teachers	☐	☐	☐

	Yes	No	Not Sure		Yes	No	Not Sure
Rigid or Inflexible	☐	☐	☐	Difficulty with peers	☐	☐	☐
Impulsive	☐	☐	☐	Overly sensitive to sound	☐	☐	☐
Temper Tantrums	☐	☐	☐	Overly sensitive to touch	☐	☐	☐
Sucks Thumb	☐	☐	☐	Overly sensitive to odors	☐	☐	☐
Few or no friends	☐	☐	☐	Tics	☐	☐	☐
Socially Immature	☐	☐	☐	Phobias	☐	☐	☐
Perseverates (talking on topic)	☐	☐	☐	Emotional	☐	☐	☐
Low Frustration Level	☐	☐	☐	Overly sensitive	☐	☐	☐
Overreacts	☐	☐	☐	High tolerance for pain	☐	☐	☐
Destructive Behavior	☐	☐	☐	Low tolerance for pain	☐	☐	☐
Aggressive Behavior	☐	☐	☐	Compliant	☐	☐	☐
Cyclical Behavior (good days/bad days)	☐	☐	☐	Cooperative	☐	☐	☐
Academic Output (good days/bad days)	☐	☐	☐	Obedient	☐	☐	☐
Achievement (high in some cases, low in others)	☐	☐	☐	Organized	☐	☐	☐
Disorganized	☐	☐	☐	Flexible	☐	☐	☐
Likes Competitive Games	☐	☐	☐	Social	☐	☐	☐
Avoidance Behavior	☐	☐	☐		☐	☐	☐

5. PHYSICAL MOTOR SKILLS (please check problem areas)

☐ Low Muscle Tone
☐ High Muscle Tone
☐ Coordination
☐ Crawling (on stomach)
☐ Creeping (on hands and knees)
☐ Walking
☐ Running
☐ Athetoid Movement
☐ Ataxic
☐ Weak
☐ Balance
☐ Other _____

6. HAND PREFERENCE

	Right	Mixed	Left		Right	Mixed	Left
Writing				Brushing Teeth			
Eating				Combing Hair			
Throwing				Other:			

7. LANGUAGE AND READING SKILLS

	Yes	No	Not Sure		Yes	No	Not Sure
Articulation Problems				Mirror Writing			
Stammer or Stutter				Forgetful			
Aphasia				Right/Left Confusion			
Poor Pencil Grip				Poor Judge of Time			
Sloppy Writing				Poorly Organized			
Poor Reading Ability				Letter Reversals			
Difficulty Copying from a Blackboard							

8. MATH (Please check areas of concern)

	Yes	No	Not Sure		Yes	No	Not Sure
Computation				Poor Logic			
Concepts				Math Facts			
Word Problems							

9. COGNITIVE (Please check areas of concern)

	Yes	No	Not Sure		Yes	No	Not Sure
Visualization				Conceptualization			
Long-Term Memory				Short-Term Memory			

10. DEVEL0PMENTAL HISTORY

Age…

…crawled (on stomach)	Years/Months _____	…used couplets (2 words together)	Years/Months _____
…creep (on hands and knees)	Years/Months _____	…3-4 word phrases	Years/Months _____
…walked	Years/Months _____	…sentences	Years/Months _____
…toilet trained	Years/Months _____	…conversational language	Years/Months _____
…first word	Years/Months _____	…read	Years/Months _____

Does the client enjoy watching television? ☐ Yes ☐ No

Does the client enjoy reading books? ☐ Yes ☐ No

Speech and language problems? ☐ Yes ☐ No

Fine motor problems ☐ Yes ☐ No

Gross motor problems ☐ Yes ☐ No

11. EDUCATIONAL HISTORY

Present educational placement:

Days per week _____ Hours of attendance _____

☐ Private ☐ Charter ☐ Special (please indicate classification)

☐ Behavioral ☐ Public _____

List all school programs attending, years attended, and grade(s) completed.

_____

_____

List any educational problems (past or current)

_____

_____

_____

List any labels, classifications, or educational diagnoses (past or current)

_____

_____

List any exceptional abilities including academic, physical, artistic, musical, etc.

_____

_____

_____

List any classes/lessons the client is enrolled in (Musical, Physical/Sports, Art, Languages, etc.)

_____

_____

_____

Are there any events which may be currently affecting the client adversely? ☐ **Yes** ☐ **No**

Please describe _____

12. GOALS AND PLANS

What are your goals and expectations?

_____

_____

_____

_____

_____

_____

Who will implement the program? _____

Daily length of time parents can work with client? _____

Daily length of time others can work with client? _____

13. PARENT/GUARDIAN CONCERNS AND HOME ADJUSTMENT

Academic / learning concerns:

Personal / emotional concerns:

Social / relationship concerns:

Behavioral concerns:

Physical / developmental concerns:

What would you most like to see improve as a result of this program?

At home, how would you describe your child's general adjustment?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Please explain any home adjustment concerns:

How does your child generally get along with:

	Excellent	Very Good	Good	Fair	Poor
Parents / Guardians	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐
Other Adults	☐	☐	☐	☐	☐
Children the Same Age	☐	☐	☐	☐	☐
Younger Children	☐	☐	☐	☐	☐

Top Priorities and Strengths

1. Greatest concern:
2. Greatest concern:
3. Greatest concern:
1. Greatest strength:
2. Greatest strength:
3. Greatest strength:

14. PREGNANCY, LABOR AND DELIVERY HISTORY

Gestational age at birth: ☐ weeks ☐ Premature - Yes ☐ No

Birth weight: ☐ lbs ☐ oz NICU stay: ☐ Yes ☐ No How long: ☐

Pregnancy history (check all that apply):

☐ Significant maternal illness / infection
☐ Significant injury during pregnancy
☐ Significant or prolonged stress
☐ Prescription medication during pregnancy
☐ Tobacco / nicotine exposure
☐ Alcohol exposure
☐ Other substance exposure
☐ None known

Medications taken by mother during pregnancy: ☐

Please describe any significant pregnancy illness, infection, injury, medication, exposure, or stress:

☐

Labor and delivery:

☐ Spontaneous labor ☐ Induced labor ☐ Scheduled delivery Length of labor: ☐
☐ Vaginal delivery ☐ Cesarean section ☐ Emergency cesarean section

Were any of the following involved? (check all that apply)

☐ Breech presentation ☐ Forceps ☐ Vacuum extraction
☐ Fetal distress ☐ Umbilical cord complications ☐ Meconium
☐ Maternal infection / fever ☐ Oxygen after delivery ☐ Ventilator / respiratory support
☐ Jaundice ☐ NICU admission ☐ Other

Were there complications during labor or delivery? If yes, please describe:

☐

Did the baby require special care immediately following birth? If yes, please describe:

☐

Difficulty feeding or gaining weight as an infant? ☐ Yes ☐ No

15. EARLY DEVELOPMENT, FEEDING, ORAL HABITS AND SLEEP

Developmental milestones - approximate age achieved:

Milestone	Years	Months	Milestone	Years	Months
Rolled over			First word		
Sat independently			Two-word phrases		
Crawled on stomach			3-4 word phrases		
Crept on hands and knees			Sentences		
Pulled to stand			Conversational language		
Walked independently			Toilet trained		
Fed self independently			Dressed independently		

Has your child ever lost a skill that he or she previously had? ☐ Yes ☐ No

If yes, describe the skill(s), approximate age, and circumstances:

Feeding / oral-motor history (check all that apply):

- ☐ Difficulty nursing
- ☐ Difficulty taking a bottle
- ☐ Poor suck
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Gagging / choking
- ☐ Reflux
- ☐ Poor weight gain
- ☐ Difficulty transitioning to solids
- ☐ Food texture sensitivities
- ☐ Very selective / limited foods
- ☐ Excessive drooling
- ☐ Mouth breathing
- ☐ Tongue tie / lip tie
- ☐ Other feeding concern

Describe any feeding problems during infancy or childhood:

Thumb / finger sucking - until what age?

Pacifier use - until what age?

Sleep history (check all that apply):

- ☐ Difficulty falling asleep
- ☐ Frequent waking
- ☐ Restless sleep
- ☐ Snoring
- ☐ Mouth breathing during sleep
- ☐ Night terrors
- ☐ Sleepwalking
- ☐ Does not appear rested
- ☐ Previous sleep study

Age child began sleeping through the night:

Describe any significant feeding or sleeping problems:

16. MEDICAL, INJURY, HOSPITALIZATION AND MEDICATION HISTORY

Has your child ever had a serious accident or injury? ☐ Yes ☐ No

If yes, describe the accident/injury, age/date, treatment, and any lasting effects:

Has your child ever lost consciousness? ☐ Yes ☐ No

If yes, please explain:

Has your child ever been hospitalized? ☐ Yes ☐ No

Hospitalizations:

Age / Date	Reason for Hospitalization	Length of Stay

Current medications (prescription and over-the-counter):

Medication Name	Dosage	Frequency	Reason

Has your child taken medication in the past for attention, behavior, mood, sleep, or learning? ☐ Yes ☐ No

If yes, list the medication(s), dosage if known, reason, and response:

Are there any current medical concerns or limitations not already listed on this form? ☐ Yes ☐ No

Please describe:

17. SENSORY, COMMUNICATION, SOCIAL AND DAILY LIVING HISTORY

Sensory processing - indicate the response that best describes your child:

Area	Avoids / Sensitive	Seeks	No Concern
Sound	☐	☐	☐
Touch	☐	☐	☐
Movement	☐	☐	☐
Light / Visual Input	☐	☐	☐
Smell	☐	☐	☐
Taste / Food Textures	☐	☐	☐
Pressure / Hugs	☐	☐	☐
Spinning / Swinging	☐	☐	☐

Communication and social development:

Responds consistently to name	☐ Yes	☐ No	Makes appropriate eye contact	☐ Yes	☐ No
Initiates interaction with others	☐ Yes	☐ No	Participates in back-and-forth conversation	☐ Yes	☐ No
Understands humor / sarcasm	☐ Yes	☐ No	Understands facial expressions / body language	☐ Yes	☐ No
Prefers adults to same-age peers	☐ Yes	☐ No	Prefers solitary play / activities	☐ Yes	☐ No
Engages in imaginative / pretend play	☐ Yes	☐ No	Has difficulty with changes in routine	☐ Yes	☐ No

Daily living / independence - check areas in which your child requires assistance:

☐ Dressing	☐ Bathing	☐ Toileting
☐ Grooming	☐ Eating	☐ Preparing food
☐ Household chores	☐ Managing belongings	☐ Managing time / schedule
☐ Money skills	☐ Safety awareness	☐ Community independence

Other daily living concerns:

Family history - check all that apply:

☐ Autism	☐ ADHD	☐ Dyslexia / learning disability
☐ Speech / language delay	☐ Intellectual disability	☐ Seizures
☐ Developmental delay	☐ Anxiety	☐ Depression
☐ Bipolar disorder	☐ OCD	☐ Addiction / substance abuse
☐ Genetic disorder	☐ Other	

Relationship(s) to child and additional details:

18. EDUCATIONAL EXPERIENCE AND REMEDIAL SUPPORT

In general, how would you describe your child's experience with learning and school from kindergarten to the present time?

Overall, how would you describe your child's academic experience?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Has your child struggled significantly in any of the following areas? (check all that apply)

☐ Reading ☐ Reading comprehension ☐ Spelling

☐ Written expression ☐ Handwriting ☐ Mathematics

☐ Memory ☐ Attention / concentration ☐ Following directions

☐ Completing assignments ☐ Organization ☐ Test taking

☐ Other

Other academic concerns:

Has your child received remedial, tutoring, therapeutic, or educational help outside of the school system? ☐ Yes ☐ No

Outside / remedial support:

Type of Help	Provider	Age / Grade	Duration	Outcome

Has your child ever repeated a grade? ☐ Yes ☐ No Grade: Reason:

Has your child ever been retained, socially promoted, skipped a grade, homeschooled, or changed schools because of academic, developmental, social, or behavioral concerns? ☐ Yes ☐ No

If yes, please explain:

When did you first become concerned? Age / Grade:

What did you first notice about your child's development, learning, behavior, or social development?

Is there anything else about your child's school experience or learning history that would be helpful for us to know?

I look forward to working with you and your family!