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CONNECTIONS
PEDIATRIC THERAPY

Preschool Health History

Today's date:_____

IDENTIFYING INFORMATION:

Child's name: _____

Date of birth: _____ Age: _____ Yrs. _____ Mos. Sex: M F

School: _____

Grade:_____

Parent names:_____

Stepparents involved:_____

Child lives with:_____

Other family members (list ages and in/out of home):

Biological siblings:_____

Step siblings:_____

Others:_____

Primary language spoken in home:_____

REASON FOR REFERRAL:

Referred by: _____

Reason for visit: _____

When was the reason first noticed? _____

By whom? _____

Diagnosis (list type and dates): _____

Previous evaluations (list type and dates): _____

Current/previous therapy (list type and dates): _____

Current Medications (list dosage):_____

_____

What are your concerns about your child?_____

What do you hope will be gained by having your child seen at this clinic?

_____

_____

_____

MEDICAL CONTACTS:

Pediatrician: _____ Group or practice: _____

Other physicians or therapists:_____

Name:_____ Group or practice:_____

Name: _____ Group or practice:_____

Name: _____ Group or practice:_____

PREGNANCY/BIRTH HISTORY:

For children three and under please complete all information below.
For children three and older please record any notable information. Describe any complications during pregnancy:

During the pregnancy with this child did the mother:	**Check if "Yes"**	**When?**	**Explanation**
Drink alcoholic beverages? (indicate how much)			
Smoke? (indicate how much)			
Take medications or drugs other than vitamins and iron?			
Use drugs?			
Have high blood pressure?			
Have toxemia?			
Have spotting or bleeding?			
Have any severe accidents?			
Have German measles?			
Have any x-rays taken?			
Have unusual physical strain?			
Have prescribed bedrest?			
Have unusual emotional strain?			
Have other illnesses or medical problems?			
Other			

Medical care was begun during which month of pregnancy: _____
Length of pregnancy (in weeks): _____ Length of hospital stay: _____
Length of labor:_____ Birth weight: _____
Was labor induced? Yes No Type of anesthesia: _____
Birth was:
Normal? Yes No Caesarean? Yes No Breech? Yes No
Twins or More? Yes No Were forceps/vacuum extractor used? Yes No
Did mother have complications? Yes No
If yes, please specify:
_____
_____
_____

Did baby need medical assistance in starting to breathe? Yes No
If so, how long before normal breathing was established? _____
What means were used to establish normal breathing? _____
APGAR Score: At 1 minute _____ At 5 minutes _____
Was baby in NICU? If yes, for how long?_____
Was baby in incubator? Yes No If so, for how long?_____

CHILDHOOD MEDICAL HISTORY:

Check any of the following that apply. List age and explanation:

Item	**Check if "Yes"**	**Age**	**Explanation**
Regular Medications (please list)			
Convulsions/seizures			
Meningitis			
Encephalitis			
Injury to head			
Fainting spells			
Measles			
Chronic illnesses			
Constipation			
Reflux			
Allergies			

Item	Check if "Yes"	Age	Explanation
Chronic Cough			
Asthma			
Heart disorders			
Stomach or intestinal disorders			
Reactions to immunizations (specify)			
Chronic ear infections			
Hearing exam/poor hearing			
Vision exam/poor eyesight			
Sleep disorders			
Eating disorders			
Hospitalizations (give details)			
Other			

FAMILY HISTORY:

Check any of the following that apply. List relationship (i.e. mother, brother), and explanation:

Family History of...	Check if "Yes"	Family History	Explanation
Learning Disorders			
Emotional Disorders			
Genetic Disorders			
Attention Disorders			
Speech/Language Disorders			
Substance Abuse			
Other			

MOTOR DEVELOPMENT:

Check any that apply. List age that your child achieved this skill:

Skill	**Age**	**Skill**	**Age**
Smiled		Bowel Trained	
Followed with eyes		Went to bathroom alone	
Reached for objects		Undressed him/herself	
Rolled over		Dressed him/herself	
Sat without support		Used buttons, zippers, and snaps	
Crawled		Skipped	
Pulled to stand		Rode tricycle	
Stood without support		Used eating utensils	
Walked alone		Used writing utensils	
Bladder Trained		Used scissors	

SPEECH AND LANGUAGE DEVELOPMENT:

Check any of the following that apply:

My child communicates by…	**Check if "Yes"**	My child communicates by…	**Check if "Yes"**
Gestures		Crying	
Single words		Conversation	
Eye gaze		Sign language	
Phrases		Augmentative device	

Describe VERBAL BEHAVIOR: _____

_____

_____

_____

Can you understand your child's speech? Yes No Can others? Yes No

Does your child stutter? Yes No

If yes, describe:_____

Estimate vocabulary size: 0 words 1-25 words 25-50 words 50-100 words over 100 words

Describe LISTENING BEHAVIOR: _____

_____

_____

Can your child follow directions? Yes No

Can your child answer simple questions? Yes No

EATING/SWALLOWING BEHAVIORS:

Describe typical foods/liquids consumed at:

Breakfast:_____

Lunch: _____

Dinner: _____

Quantity of liquids consumed per day: _____

What does your child drink from? (sippy cup, cup, etc.) _____

How does your child eat? (spoon-fed, finger foods, spoon, fork, adaptive equipment)

_____

Does your child have a good appetite? Yes No

Is your child a picky eater? Yes No

Does your child choke frequently? Yes No

Does your child drool? Yes No

Does your child refuse any food tastes, textures, or temperatures? Yes No

If yes, describe: _____

_____

_____

_____

ACADEMIC/EDUCATION DEVELOPMENT:

Pre-school: _____ Phone: _____

Address: _____

Days per week: _____ Teacher: _____

History:

Preschools/Schools Attended	Years

Academic Behaviors	Check all that apply	Academic Behaviors	Check all that apply
Poor physical coordination		Letter formation	
Poor memory, short-term and long-term		Right-left confusion, directionality problems	
Reluctance/refusal to use one hand		Late letter recognition	
Conflict with teacher		Certified for special education (LD resource help, MR, Speech, etc.)	

SOCIAL/EMOTIONAL BEHAVIORAL DEVELOPMENT:

Who generally disciplines the child? _____

What methods are used: _____

Do parents agree on methods of discipline? Yes No

If no, describe: _____

_____

_____

Check any of the following that apply:

Behaviors	Check all that apply	Explanation
Difficulty sleeping ☐ and/or Nightmares ☐		
Enuresis (wetting) ☐ and/or Encopresis (soiling) ☐		
Sucks thumb		
Difficult to discipline		
Difficulty with brothers and/or sisters		
Difficulty in getting along with other children		
Lacks age appropriate play skills		
Avoids peer interactions or other unfamiliar social contacts		
Socially inappropriate		
Does not look where you point		

Behaviors	**Check all that apply**	**Explanation**
Does not look to you for reassurance		
Inattentive ☐ and/or Impulsive ☐ and/or Distractible ☐		
Anxiety ☐ and/or Separation anxiety ☐		
Difficulty with transitions		
Resists changes in environment		
Argumentative		
Destructive		
Self conscious/easily embarrassed		
Motor and/or vocal tics		
Oddities of speech or motor movement		
Low productivity at school, work, home		
Overly dependent/helpless		
Chronically tired or irritable		
Headaches, stomachaches, nausea		
Odd/bizarre ideas		

Additional comments:

_____

_____

_____

_____

_____

Please note any major changes in your child's family, school, social life in the last 6–9 months, which could be important. If there is any specific information which has not been requested on this form but which would help us in understanding your child's problems, please include here:

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_____

Thank you for taking the time to complete this form. It will help us serve your family better. If you have other critical documentation related to your concerns, please bring copies of records to your next appointment.