Integrated Pediatric Therapy

SENSORY MOTOR HISTORY

Child's Name:_____ Date of Birth: __ Age: ____ Sex: M/F

Name of person completing form: _____ Date:_____

Are there any physical or medical precautions or activity restrictions (e.g.: due to heart problems, asthma, seizures, physical limitations, etc.)?

Is your child currently on any medication? No _____ Yes _____ Purpose:_____
Names of medication, dosage, side effects:

Please specify significant allergies or food restrictions:

Pregnancy and Birth History

Are you your child's birth/step/adoptive parent(s)?
If not the birth parents:
Pre- and post-natal environments (eg: institution)?
At what age did the child come into your care?

Medications taken during pregnancy (name and purpose):

Problems / difficulties experienced during pregnancy:

___ bleeding ___ toxemia ___ diabetes ___ severe nausea
___ emotional stress ___ infection ___ premature labor ___ other:

How was it treated?

Labor / Delivery:
Full-term or premature? _____ Gestational age:_____ Birth weight: _____

___ fetal monitor ___ forceps ___ vacuum extraction ___ C-section
___ water broke > 24 hours before delivery ___ cord around neck ___ breech
___ meconium aspirated ___ birth injuries ___ delayed cry ___ limpness
___ Other:

Neonatal:

___ oxygen needed ___ NICU needed ___ medical intervention

___ irritable ___ difficulty nursing ___ poor suck

___ difficulty regulating temperature ___ jaundice ___ Other:

Developmental Milestones:

Were feeding and sleeping patterns easily established?

Fussy baby? (If so, was it due to colic and did it go beyond 6 mos. of age?)

At what age did your child consistently sleep through the night?

Indicate child's age for/or if age not remembered, was milestone early, late, or typical:

_____ independent sitting _____ hands/knees crawling _____ walking

_____ first words _____ sentences _____ toilet trained _____ _____
day night

Do you think that any part of your child's development is slower than average? If yes, explain:

Current areas of concern (please mark all that apply):

____Gross Motor Development	____Sports	____Fine MotorDevelopment
____ Handwriting	____Pencil Grasp	____Language
_____Social Skills	____Eating	____Sleeping
_____Reading	____Spelling	____Math
_____Motivation	____Moodiness	____Concentration
_____Neatness	____Organization	____Self-confidence
_____Getting along with adults	____ Getting along with peers	_____Attention/focus

_____Frustrations (list):

_____Fears (list):

When did you first notice your child's difficulties and how were they apparent to you?

Is there a family history of similar difficulties? If so, who and what are the difficulties?

Please list any previous medical and/or diagnostic tests or evaluations (i.e. neurological, speech, education, other) and their results. If possible, please attach copies of relevant reports.

Significant test results:

Any diagnosis given:

Please check if your child has received services from any of the following:

_____ Occupational Therapy _____ Physical Therapy _____ Speech Therapy

_____ Tutoring _____ Psychological Counseling _____ Special Ed. Classes

If so, when, where (private or through school), and for how long?

Are these services ongoing?

Medical and Behavioral History

Please indicate all that are applicable and ages(s):

_____ High fevers	_____ Meningitis	_____ Ear infections / tubes
_____ Chicken pox	_____ Whooping cough	_____ Heart trouble
_____ Mumps	_____ Scarlet fever	_____ Excessive vomiting
_____ Allergies	_____ Seizures	_____ Lung / bronchial difficulties
_____ Epilepsy	_____ Diabetes	_____ Surgery / hospitalization

Other significant accidents, injury, illness?

Mark with a "C" if this is a Current behavior or "P" if it is a behavior previously demonstrated.

_____ Drools excessively	_____ Resists being held/hugged	_____ Likes to cuddle
_____ Easy to manage	_____ Tense when held/hugged	_____ Likes being held
_____ Very active	_____ Cries, fussy, irritable, “colicky”	_____ Alert
_____ Good sleep patterns	_____ Irregular sleep patterns	_____ Quiet or passive

Comments:

What are your child's most preferred activities?

Indoors:

Outdoors:

What are your child's least favorite activities?

Indoors:

Outdoors:

Does your child tend to have difficulty learning new motor tasks/games?

Does your child resist participating in fine or gross motor tasks? Please explain:

Please describe your child’s ability to independently organize and keep track of personal belongings, both at home and school.

Does your child have any newly/recently acquired skills?

Does your child demonstrate right or left-hand dominance?

Do any family members have left-hand dominance?

Check the following items that best describe your child. If it was true for your child in the past but not currently, please put a “P” rather than a check mark.

Visual

____ Wears glasses
____ Has a diagnosed visual problem (describe):
____ Has difficulty finding / seeing things (shoes in the closet, toy in a toy basket)

Auditory and Communication

____ Has a suspected or diagnosed hearing loss
____ Limited or absence of gesturing to assist communication
____ Excessive talking interferes with listening

If your child is nonverbal, how does he/she communicate?

Are there certain noises that your child cannot tolerate? If so, please give examples:

Oral-Motor and Respiratory Control

____ Displays poor lip control/lip closure for eating, drinking, using utensils
____ Has limited skills with blow toys, whistles, bubbles
____ Demonstrates poor saliva control (drools)
____ Chokes easily on liquids or solids. Specify:
____ Clenches jaw or grinds teeth
____ Holds breath frequently
____ Breathes with mouth open / often has mouth open
____ Noisy breathing / snores

Daily Routines

DRESSING

Is your child able to: (Check those which your child CAN do, circle if options)

__ Dress/Undress
__ Button/Unbutton
__ Snap/Unsnap
__ Zippers pull/engage/disengage
__ Jacket on/off
__ Velcro shoes on/off
__ Ties shoes
__ Socks on/off
__ Notice when clothes are backwards, twisted, wet, or fasteners undone

Approximately how much time does it take for your child to get dressed in the morning and how much assistance/reminders is/are needed from an adult?

HYGIENE/GROOMING

Is your child able to:

__ Allow an adult to wipe his/her face, brush teeth, brush/style hair
__ Allow an adult to his/her wash hair
__ Brush teeth
__ Wash/rinse self in tub or shower
__ Wash and dry hands at home

TOILETING

Is your child able to :

__ Wipe effectively
__ Manage clothes for toileting
__ Get to toilet without reminders
__ Wash and dry hands in a public restroom (use varied faucets, towel dispensers, air dryers)

Do the noises in a public restroom (flushing toilets, air dryers) interfere with your child using one?
If your child has difficulty with controlling bowel and / or bladder (day or night or both), please explain:

EATING
Is your child able to:
__ Remain seated for a family meal for 10 minutes (If not, how long can your child last? _____)
__ Eat liquid foods (such as soup or cereal with milk) without spilling (If not, what % is spilled? ___)
__ Use eating utensils for majority of foods
__ Spread with a knife (such as jam, cream cheese, or peanut butter)
__ Pour liquid into a glass without spilling
__ Open a variety of food storage containers (e.g.: zip-lock bags, snap lid, screw top)
__ Open a variety of snack-food packaging (e.g.: chip bag, bar wrapper, straw wrapper)
__ Get self a snack or something to eat if hungry

Is your child what you would describe as a "picky eater"? If so, please describe the foods your child will eat or those he/she won't eat (whichever is easier for you).

Does your child seem to crave or avoid certain kinds of foods (eg, sweet, crunchy, sour, salty, creamy)?

Does your child tend to stuff too much food into his/her mouth?
Does your child tend to gag or cough during or just after eating? If so, is it frequent?

Please list what your child will typically eat in the following categories:
Vegetables:
Fruits:
Proteins:
Dairy products:
Grains/carbohydrates:
Fast foods:
Snacks:
Beverages:

Are there any categories of food that your child avoids or refuses?

Are there foods that your family typically eats that your child will not?

COMMUNITY
Is your child able to:
__ Get in and out of the car independently (including opening and closing door)
__ Buckle seat belt
__ Stay close to adult while walking on a sidewalk
__ Avoid people and obstacles while walking in a public area
__ Demonstrate awareness and avoidance of hazards in the immediate area
  __ others playing nearby (swings, thrown balls, running/chasing) or vehicles in motion
  __ cones, barricades, construction tape, etc.
  __ doors opening
  __ changes in walking surface (curbs, raised cracks, etc.)
__ Participate in family activities such as extended family gatherings or visiting at relatives' homes

Does your child have difficulty tolerating noisy or busy environments such as grocery stores, malls, or birthday parties?

PHYSICAL ACTIVITIES
How long can your child participate in a physical activity before fatiguing?
What is your child's choice of physical activity?
Outside of school, how much time does your child engage in physical activities?
Outside of school, how much time does your child participate in sedentary activities?
Does your child participate in any group or team physical activities? If so, what and how often?
Is your child able to be in close proximity to others without touching or bumping them?
Does your child engage in behaviors that may be harmful to self or others?

SLEEP
Is your child able to:
__ Get himself/herself to sleep (vs. falling asleep while adult is present)
__ Sleep in own bed
__ Sleep through the night
__ Get self back to sleep if awakens in the night
__ Awaken on own in the morning
How many hours/night does your child usually sleep?
Does your child nap/fall asleep in the daytime? If so, for how long?
Are you able to get adequate sleep? If not, what are the disruptions?

Temperament/Social

1. Can your child independently calm down after periods of exciting activity or after being upset? What strategies can be helpful?

2. Please describe how your child approaches and explores a new environment.

3. Does your child exhibit any repetitive, idiosyncratic, or self-stimulating patterns of behavior? If so, please describe behavior and typical situations in which it may occur.

4. Does your child have friends? If so, do they tend to be the same age, older, or younger?

5. Does your child ask to have a friend come to the house?
   Do friends ask to have your child come to play at their house?
   If so, for what amount of time can your child participate in a "play date"?

6. When playing, does your child usually choose to be a leader, a follower, or a solitary player, and with how many people at a time is your child comfortable playing?

7. Please describe any strategies your child uses to help himself/herself sustain focused attention (e.g., chewing on pencil or shirt, shaking/bouncing leg, turn on or off background music, etc.).

8. When does your child become most frustrated?

9. Does your child seem irritable at predictable times of the day? If yes, please describe the times of the day when your child seems irritable and the events that seem likely to trigger frustration.

10. When is your child most calm or happy? Does your child seem happier or more cooperative at predictable times of the day? If yes, please describe the times of the day when your child seems happiest and most cooperative, and the events that seem likely to precede these behaviors.

Family Resources

The family plays a primary role in developing a child's potential. This information will help us support your child's performance across environments. Please list:

Names and ages of everyone living in the home:

Any health concerns in the family:

Others who can help care for your child or implement supplemental therapy activities (e.g., extended family, sitters, ABA providers, etc.):

Given your needs and those of your family, how much time/energy do you and others have available to work with your child on areas of concern (e.g., none, 1 hr./day; 2x/week, etc.)?

Are you satisfied with the level of support available to you?

On a scale of 1-10, with 1 being "not stressful" to 10 being "extremely stressful", please rate your current level of stress.

What changes would make a positive difference in your family's quality of life?

Are there family circumstances or culturally based issues that may be important for us to consider?

Summary

What things do you enjoy most about your child?

What are your main concerns about your child's functioning?

What do you think hampers his/her performance?

What do you think is most helpful to him/her achieving success?

Is there any other information that you would like to share about your child?

Thank you for your information.