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SENSORY MOTOR AND MEDICAL HISTORY FORM
(Birth to 12 Months)

Please fill in the questionnaire as completely as possible. Return the completed form 48 hours before beginning services.

GENERAL INFORMATION
Child's Name: _____
Birth Date: _____ Age: _____ Sex: _____
Reason for referral: _____
_____
Who referred you to our practice: _____
Parent Name: _____
Education: _____ Occupation: _____
Parent Name: _____
Education: _____ Occupation: _____
Marital Status: __ Married __ Partner __ Separated __ Divorced __ Widowed __ Single

PRENATAL AND NATAL HISTORY
Is he/she your biological child? Yes No If no, please explain: _____
_____
Is child adopted? Yes No If yes, at what age? _____
Full Term: _____ (38 to 42 weeks)
Premature: _____ (before 37 weeks) How many weeks? _____
Birth Weight: ___ lbs ___ oz Birth Length: _____

Please check any problems encountered during pregnancy?
___ Injuries ___ Stress ___ Bleeding ___ Anemia ____ Placenta Previa
____ Preeclampsia ____ High blood pressure ____ Anxiety/Depression
____ Other (illnesses, seizures, etc.): _____
Diet during pregnancy: ___ regular ___ vegetarian ___ vegan
Prenatal vitamins? Yes No
Additional supplements? Yes No If yes, what? _____
Medications taken during pregnancy: _____
Is this your first child? Yes No
Delivery (check all that apply): ____ Vaginal ____ Forceps and/or Vacuum Extraction
____ Induction ____ Planned C-Section ____ Emergency C-Section
What kind of anesthesia? _____

Problems with labor (check all that apply)? Yes No
____ Breech ____ Limpness ____ Stiffness ___ Breathing Issues
At the time of delivery, did you infant have trouble with any of the following (check all that apply):
____ Cyanosis ____ Jaundice ____ Pallor ____ Heart rate ____Reflexes ____ Breathing
____ Congenital defects ___ Infantile spasms/seizures
Was there a need for any of the following?
___ Oxygen ____ Transfusions ___ Tube Feedings ___CPAP ____ Ventilator
Were there any feeding difficulties after birth? Yes No
Please explain: _____
____ Bottle Fed ____ Breast Fed ____ Combination
Did your baby go home from the hospital with you? Yes No
Length of hospitalization: _____

GENERAL HEALTH
Immunizations Current? Yes No
If no, please list which are not up to date according to recommended schedule: _____
_____
Feeding
Are there any feeding problems now (check all that apply)?
___ Poor suck ___ Difficulty swallowing ___ Difficulty chewing ____ Gagging/choking
___ Tube fed ____ Reflux/vomiting ___ Other _____
Reflux Medication: Yes No
Are there any bladder/bowel difficulties? Yes No Please explain: _____
_____
Nutrition (check all that apply): ____ Bottle _____ Formula _____ Pureed _____ Solids
Food Allergies/Sensitivities Yes No Please list:
_____
_____

Illness/Injuries
Any Other Allergies (environmental) or Asthma? Yes No Please list: _____
_____
Any Medication (please list): Yes No Please list:
_____
_____
Illnesses (check all that apply):
____ RSV ____ Pneumonia ____ Bronchitis ____ BPD ____ Tonsillitis
____ Head Injuries ____ Fractures ____ Other: _____
___ Seizures: When diagnosed? _____ Type? _____
Frequency _____ Medications _____
___ Ear Infections: Frequency/how many? _____
Antibiotics? Yes No How many rounds? _____
Surgeries (check all that apply):
____ Ear tubes ____ G-tube ____ Heart Repair ____ Trach ____ Shunt

List dates: _____
List hospitalization dates and reasons:_____
_____
_____
Tests performed (check all that apply):
___ MRI ___ CT Scan ___ Ultrasound ___ Genetic testing ____ X-rays ___
___ Blood work:
_____
___ Other: _____

PHYSICIANS
Child's Regular Pediatrician:
_____
Address: _____ City _____ State _____
Zip _____ Phone Number: _____

Please check all that apply:

Yes	Specialty	Reason	Result
	Neonatologist Name:		
	Lactation/Feeding Specialist Name:		
	Pediatric Neurologist Name:		
	Developmental Pediatrician Name:		
	Pulmonologist Name:		
	Gastroenterologist Name:		
	Orthopedist		

	Name:		
	ENT Name:		
	Occupational Therapist Name:		
	Physical Therapist Name:		
	Speech Language Pathologist Name:		

Have you or are you planning to contact early intervention services? Yes No
Reason(s) seeking early intervention services: _____
_____

DEVELOPMENTAL HISTORY

Tummy Time

Does your baby enjoy being on their tummy for play? Yes No
How long does your child play in this position? _____ minutes _____ times/day

Sleep

How many hours does your baby sleep at night? _____
How many times does your baby wake in the night? _____
How many times does your baby feed in the night? _____

Does your baby…? Please check all that currently apply
___ smile in response to sound/voice ___ smile in response to touch
___ smile in response to bottle/breast ___ smile in response to faces
___ quiet when picked up ___ enjoy physical contact ___ enjoy being rocked
____ enjoy bouncing ____ become bothered during car rides
___ follow a person with his/her eyes ___ swipe at objects ____ coo or babble
____ respond to name ____ use consonants (how many? ____) ____ follow simple directions
___ open/close mouth with food stimulation ___ take hands to feet while on back
___ roll to right back to tummy ___ roll to left back to tummy
____ roll to right tummy to back ___ roll to left tummy to back
___ hold toy briefly in 1 hand ____ hold toy briefly in 2 hands
___ transfer objects from one hand to other ___ bring hands to the middle

Developmental Milestones
List approximate age your baby accomplished the following:
Lifted head while on tummy _____ Rolled over _____ Sat without support _____
Belly crawled _____ Crawled on hands and knees _____ Stood Unassisted _____
Cruised _____ Walked _____

Who else lives in the home?

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

PARENTAL CONCERNS AND GOALS
Please list any concerns you would like to share with us regarding your child:
_____
_____
Please list 3 goals you would like your child to work on:

1. _____
2. _____
3. _____