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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 _____

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. _____