

**SENSORY MOTOR AND MEDICAL HISTORY FORM**  
(12 months to 36 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)?

\_\_\_ 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: \_\_\_\_\_

Food Allergies/Sensitivities Yes No Please list: \_\_\_\_\_

### Illness/Injuries

Any Other Allergies (environmental) or Asthma? Yes No Please list: \_\_\_\_\_

Any Medication(s): Yes No Please list: \_\_\_\_\_

Previous 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? \_\_\_\_\_

Previous 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: \_\_\_\_\_

Does your child have a diagnosis? Yes No  
 If yes, what is the diagnosis? \_\_\_\_\_  
 Who provided this diagnosis and when? \_\_\_\_\_  
 \_\_\_\_\_

**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:

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### DEVELOPMENTAL HISTORY

#### Sleep:

How many hours does your child sleep at night? \_\_\_\_\_

How many times does your child wake in the night? \_\_\_\_\_

#### 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 \_\_\_\_\_

Check which of the following described your child **as an infant**:

Fussy  Irritable  Good  Non-demanding  Quiet  Passive  Active

Liked being held  Resisted being held  Floppy when held

Tense muscles when being held  Good sleep patterns  Irregular sleep patterns

Over-active, never still unless sleeping

Comments: \_\_\_\_\_

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#### Speech/Language History:

Give approximate ages at which child did the following:

Babbled \_\_\_\_\_ Said first word \_\_\_\_\_

Examples of first words: \_\_\_\_\_

Combined two words \_\_\_\_\_ Give example \_\_\_\_\_

Used 3-4 word sentences \_\_\_\_\_ Give example \_\_\_\_\_

Obedied simple commands \_\_\_\_\_

**PRESENT LEVEL OF FUNCTION:**

**Play:**

With whom/who does the child spend most of his day? \_\_\_\_\_

How does your child choose to use his/her free time? \_\_\_\_\_

Does your child play appropriately with toys? Yes No

If no, explain:

\_\_\_\_\_

**Discipline:**

Who is responsible for discipline/rule setting in the home: \_\_\_\_\_

What methods are used and what seems most effective? \_\_\_\_\_

How does the child react to discipline? \_\_\_\_\_

Does the child tantrum? Yes No

Have you observed any head banging or self-destructive behavior? Yes No

If yes, explain \_\_\_\_\_

Check which describes child **at present**:

- Usually happy    Mostly quiet    Overly active    Tires easily    Talks constantly    Too impulsive    Restless    Stubborn    Resistant to changes
- Over reacts    Clumsy    Wets bed    Fights frequently    Exhibits frequent temper tantrums    Has difficulty separating from primary caretakers    Has nervous habits or tics    Falls often    Poor attention span    Easily frustrated    Cries often    Cries infrequently    Rocks self frequently    Has difficulty learning new task

**General impression of child's motor development:**

Gross Motor:  Slow  Normal  Advanced

Fine Motor:  Slow  Normal  Advanced

Has your child achieved some skills and lost them? Yes No

If yes, what skills?

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**Sensory:**

Vestibular (movement and gravity information). Check which of the following apply to your child:  Rocks while sitting  Jumps a lot  Likes being tossed in the air   
Good balance  Fearful of heights  Fearful of movement  Likes Merry-Go-Rounds   
Spins & whirls more than other children  Gets car sick  Enjoys being rocked  Prefers quiet play as opposed to more active play  No fear of movement or falling

Comments: \_\_\_\_\_  
\_\_\_\_\_

Tactile (touch information). Check which of the following apply to your child:

Avoids “messy” things (mud, finger paint, etc.)  Dislikes having face washed or wiped  
 Irritated by cloth of certain textures  Objects to being touched  
 Dislikes unexpected touch  Avoids using hands for extended periods  
 Pinches, bites, or otherwise hurts him or herself  Examines objects by putting them into his/her mouth  Tends to feel pain less than others  Isolates him or herself from other children  
 Excessively ticklish  Dislikes hair washing  Dislikes nail cutting  
 Wants to handle everything  Seeks lots of touch  Dislikes teeth brushing

Comments: \_\_\_\_\_  
\_\_\_\_\_

Proprioceptive (muscle and joint information). Check which of the following apply:

Holds hands or body in strange positions  Uses too much/too little force on objects  
 Good coordination with small things (i.e., pencil, buttons)  Is clumsy  
 Walks on toes (or did when younger)  Went from sitting to standing with little or no crawling  Crept on tummy rather than hands or knees  Leaps from one position to the next, unable to move slowly from one to another

Comments: \_\_\_\_\_  
\_\_\_\_\_

Visual: Check which of the following apply to your child:

Bothered by bright light  Looks very closely and carefully at pictures or object  
 Becomes very excited when there is a variety of visual objects  Has difficulty maintaining

eye contact with another person  Difficulty following an object across the room  Difficulty following an object tossed toward him/her

Comments: \_\_\_\_\_

Gustatory-Olfactory (taste and smell information). Check which of the following apply to your child:  Chews on non-food objects  Reacts negatively to smell  Dislikes food of certain textures  Has unusual cravings for certain foods

Comments: \_\_\_\_\_

### **Self-help Skills:**

Describe degree to which child routinely performs the following:

Feeds self:  All  Most  Some  Rare

If feeds self, uses:  Fingers  Spoon  Fork

Undresses self:  All  Most  Some  None

Dresses self:  All  Most  Some  None

Is child toilet trained?  Yes  No

If yes, at what age? \_\_\_\_\_

Bladder (daytime)  Bladder (day & nighttime)  Bowel

### **Speech/Language/Auditory:**

Check which apply to your child's listening habits:

Responds only to loud sounds

Seems to ignore people when they are talking to him/her

Responds as if sound is painful (covering ears/crying)

Seems to hear properly

Seems uninterested

Doesn't respond to name/commands when there are other noises nearby

Makes strange noises/loud noises

Check the statements that best describe your child's ability to understand language:

Understands no spoken language

Understands a few words

Follows simple commands

- Understands most words
- Understands simple conversations
- Understands everything that is said to him/her

At present, how much of your child's speech can be understood?

By mother:  All  Most  Some  None

By other family members:  All  Most  Some  None

By neighbors:  All  Most  Some  None

If applicable, describe your child's speech challenges (give examples): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is any language other than English used in the home?  Yes  No

If yes, what language? \_\_\_\_\_ What percent of the time? \_\_\_\_\_

Check those which describe your child's ability to use spoken language:

- Makes no sound or on a very limited basis  Language is limited to gestures
- Babbles only  No true words  Language is limited to single words or short phrases  Uses simple sentences  Sentences are long but disorganized and hard to understand  Repeats words often or hesitates frequently  Words are difficult to understand  Voice quality is unusual (hoarse, nasal or earthy, high pitched)  Has difficulty recalling recent events
- Has trouble remembering the correct names of things  Has no apparent problems expressing himself  Seems frustrated at trying to relate events
- Stutters frequently

**School/Daycare:**

Is your child in a structured preschool or daycare program? Yes No

Name of school/program: \_\_\_\_\_

Are there any teacher concerns? Yes No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has your family experienced any recent crisis or major change (stress) that you feel is important to your child's development (financial problems, moves, job changes, divorce or separation, death, etc)? Please explain:

\_\_\_\_\_  
\_\_\_\_\_



Are there any speech, physical or learning problems among family members, relatives?

Relationship to Family Member:

Describe Problem:

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Who else lives in the home?

Name:

Age:

Relationship:

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**PARENTAL CONCERNS AND GOALS**

Please list any concerns you would like to share with us regarding your child:

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Please list 3 goals you would like your child to work on:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_