Jones
THERAPY SERVICES

615-614-8833 jonestherapyservices.com

Child History Form

Please complete this form to the best of your knowledge. If a question does not apply to your child, you may write N/A in the blank.

Child's Full Name: _____ Date of Birth: _____/_____/_____
By what name is he/she usually called: _____ Gender: M F
Home Address: _____ County: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____) _____ - _____

Mother's Name: _____ Father's Name: _____
Mother's Cell Phone: (_____) _____ - _____ Father's Cell Phone: (_____) _____ - _____
Email for Mother: _____ Email for Father: _____

Mother's Employer: _____ Phone: (_____) _____ - _____
Address: _____
City: _____ State: _____ Zip Code: _____

Father's Employer: _____ Phone: (_____) _____ - _____
Address: _____
City: _____ State: _____ Zip Code: _____

Emergency Contact Person: _____ Phone: (_____) _____ - _____

How did you find out about our center? _____

Pediatrician (first and last name): _____ Phone: (_____) _____ - _____
Practice/Clinic/Office Name: _____ Fax: (_____) _____ - _____
Address: _____
City: _____ State: _____ Zip Code: _____

May we send a report to the doctor? ☐ Yes ☐ No

Insurance Information

Child's Social Security #: _____
Mother's Social Security #: _____
Father's Social Security #: _____

Primary Insurance Company: _____ ID#: _____
Group Number: _____ Effective Dates of Plan: _____-_____
Insurance Policy Holder's Name and Date of Birth: _____

Secondary Insurance Company: _____ ID#: _____
Group Number: _____ Effective Dates of Plan: _____-_____
Insurance Policy Holder's Name and Date of Birth: _____

Current Concerns

Please list in order of priority your current concerns for your child. _____
_____
_____
_____
_____

Birth History

Was child born at full term (37-40+ weeks)? Yes No If no, how many weeks? _____

Did the mother have any of the following complications during this pregnancy? (Please check all that apply.)

- ☐ Eclampsia
- ☐ Positive for Strep B
- ☐ Gestational Diabetes
- ☐ Pre-eclampsia
- ☐ Multiple Births
- ☐ Premature Labor
- ☐ Polyhydramnios
- ☐ Substance Exposure
- ☐ Positive CMV
- ☐ Toxemia
- ☐ Positive for Herpes
- ☐ Positive for HIV
- ☐ Other: _____

Delivery was ☐ Vaginal ☐ C-Section ☐ Emergency C-section

Any of the following complications during delivery? (Please check all that apply.)

- ☐ Abruptio Placenta
- ☐ Premature Rupture of Membranes
- ☐ Breech
- ☐ Transverse
- ☐ Low birth weight
- ☐ Prolapsed cord
- ☐ Negative Vacuum
- ☐ Use of Forceps
- ☐ Non-productive/unproductive labor
- ☐ Uterine rupture
- ☐ Occiput posterior position
- ☐ Umbilical cord wrapped around neck
- ☐ Placenta previa
- ☐ Other: _____

Any of the following complications after birth? (Please check all that apply.)

- ☐ Anemia of prematurity
- ☐ Jaundice treated by light therapy and/or blanket
- ☐ Bronchopulmonary Dysplasia
- ☐ Meconium Aspiration
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Necrotizing Enterocolitis
- ☐ Club Foot
- ☐ Neonatal hypoxia
- ☐ CMV
- ☐ Oxygen dependency
- ☐ ECMO
- ☐ PDA
- ☐ Failure to Thrive
- ☐ Positive dependency
- ☐ Hyperbilirubinemia
- ☐ Respiratory Distress Syndrome
- ☐ Intrauterine Growth Retardation
- ☐ Respiratory Stridor
- ☐ RSV
- ☐ Retinopathy of Prematurity
- ☐ Thrombocytopenia (low platelet count)
- ☐ Ventilator Dependency
- ☐ VP Shunt
- ☐ IVH Bleed Grade I
- ☐ IVH Bleed Grade II
- ☐ IVH Bleed Grade III
- ☐ IVH Bleed Grade IV

Current Medications: _____
Allergies: _____
Current Vitamins, Herbs, Minerals, Homeopathics: _____

Hearing Test: Last test date: _____ Results: _____ Concerns: _____

Vision Test: Last test date: _____ Results: _____ Concerns: _____

Current Physicians or Specialists:

Name	Specialty	Reason	Date of Last Visit

Diagnostics Tests:

Test	Date of Test	Details/Results
Auditory Brainstem Response		
Biopsy		
Blood Work / Lab Tests		
Bone Density Scan		
CT scan		
EEG		
EMG		
Lower GI		
Motility Study / Empty Scan		
MRI		
NCV		
Swallow Study		
Ultrasound		
Upper Endoscopy		
X-ray		

Surgeries or Procedures:

Type	Date	Details/Results

Does the child have? (Please check all that apply.)

- ☐ Allergies
- ☐ Arteriovenous malformation (AVM)
- ☐ Anoxic brain injury
- ☐ Asthma/respiratory breathing problems
- ☐ Autism
- ☐ Baclofen pump
- ☐ Cerebral Palsy
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Chronic Ear Infections
- ☐ Periventricular Leukomalacia
- ☐ Colic
- ☐ Constipation
- ☐ Diarrhea
- ☐ Down Syndrome
- ☐ Hip subluxation
- ☐ Hydrocele
- ☐ Laryngomalacia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Vagal Nerve Stimulator
- ☐ Scoliosis
- ☐ Seizure Condition
- ☐ Sleep disorder
- ☐ Sleep problems
- ☐ Shunts
- ☐ Torticollis
- ☐ Traumatic brain injury
- ☐ Tube Feeding
- ☐ Tubes in Ears
- ☐ Reflux

Other Medical Conditions: _____

Orthopedic Conditions: _____

Additional Comments: _____

Developmental History

	What age did the child begin?
Bringing both hands to mouth	
Buttoning pants/shirt	
Come to sitting from a lying position	
Creeping or crawling alone	
Fully toilet trained	
Grabbing a toy	
Holding head up alone	

	What age did the child begin?
Pulling self to standing position	
Rolling over	
Self-bathing	
Self-dressing	
Sitting alone without support	
Standing without support	
Tying shoes	
Walking with support	
Walking unaided	
Zipping/unzipping jacket	

Description of Child (Please check all that apply.)

- ☐ Active
- ☐ Affectionate
- ☐ Aggressive
- ☐ Calm
- ☐ Cautious
- ☐ Curious
- ☐ Demanding
- ☐ Difficult to Comfort
- ☐ Distractible
- ☐ Fearful
- ☐ Fearless
- ☐ Fussy
- ☐ Insecure
- ☐ Motivated
- ☐ Passive
- ☐ Persistent
- ☐ Playful
- ☐ Shy
- ☐ Stubborn
- ☐ Withdrawn
- ☐ Other: _____

Sensory Processing and Regulation (Please check all that apply.)

- ☐ Avoids getting messy
- ☐ Seeks out (craves) touch or movement
- ☐ Stumbles or falls frequently
- ☐ Appears awkward or less coordinated
- ☐ Flaps hands
- ☐ Allows brushing of teeth
- ☐ Bangs on surface, bang/hits head
- ☐ Fatigues quickly
- ☐ Has self-abusive behaviors
- ☐ Resists certain tasks or environment
- ☐ Spins things or self
- ☐ Is sensitive to lights, sounds or noise
- ☐ Sleeps a lot
- ☐ Resists touch
- ☐ Walks on toes
- ☐ Lines up toys or objects
- ☐ Seeks out (craves) visually stimulating objects
- ☐ Seeks out (craves) stimulating sounds
- ☐ Resists certain movements (e.g. bouncing, swinging, upside down)
- ☐ Has difficulty figuring out how to move body or takes more time with movements
- ☐ Does not tolerate certain textures (e.g. clothing, surfaces, foods)
- ☐ Uses lots of pressure when touching someone or holding object
- ☐ Has difficulty transitioning from one activity to another
- ☐ Has difficulty falling asleep
- ☐ Has difficulty remaining asleep through the night
- ☐ Appears lethargic/sleepy all the time
- ☐ Has poor sense of body space, runs into things
- ☐ Seeks support for posture (e.g. leans on furniture, walls or people, holds head)
- ☐ Demonstrates stiff or rigid movement patterns
- ☐ Hyper-focused (on specific tasks, people, objects, etc.)
- ☐ Other: Please describe _____

Social/Emotional Skills (Please check all that apply.)

- ☐ Is easily distracted
- ☐ Calms self easily
- ☐ Get angry/frustrated easily
- ☐ Is aggressive towards others
- ☐ Prone to emotional outbursts
- ☐ Doesn't allow others to join play
- ☐ Has difficulty making friends
- ☐ Plays with peers
- ☐ Only plays with adults
- ☐ Prefers to play alone
- ☐ Has difficulty with separations
- ☐ Has poor eye contact
- ☐ Other: Please describe _____

Feeding

Describe any feeding problems: _____

Food Likes: _____

Food Dislikes: _____

When did the child begin?	Age	When did the child begin?	Age
Using a bottle		Using a straw	
Using a pacifier		Stop using a bottle	
Eating baby food		Stop using a pacifier	
Eating junior food		Using utensils to eat	
Eating table food		Holding bottle/cup	
Drinking from a cup		Self-feeding	
Drinking from a sippy cup			

Breast Feeding

☐ currently breast fed ____ # times per day ☐ weaned from breast feeding at age: _____

Current feeding adaptions:

☐ Thickened liquids – Consistency: _____

☐ Adapted Utensils – Details: _____

☐ Adapted Seating – Details: _____

☐ Calorie Supplements – Details: _____

☐ Tube Feeding Amount: _____ Times per day: _____ ☐ Continuous ☐ Bolus

Areas of Difficulty:

☐ Chewing ☐ Drooling ☐ Transitioning between foods ☐ Jaw shifts/slides/juts

☐ Communication needs ☐ Swallowing ☐ Understanding words

Speech Language

Does the child:	Yes	No
Have a speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple directions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, places?		

When did the child begin?	Age	When did the child begin?	Age
Babbling		Putting 2 words together	
Saying first words		Using short sentences	
Naming familiar objects			

What percentage of your child's speech do you usually understand? _____%

What percentage of your child's speech do unfamiliar listeners usually understand? _____%

Augmentative Communication Device Details: _____

Primary Communication: ☐ Verbal ☐ Non-Verbal ☐ None

Method of communication used:

☐ Vocalizations ☐ 2 words phrases ☐ Facial expressions ☐ Manual Sign language ☐ Pointing

☐ Single words ☐ Complete sentences ☐ Body language ☐ Gestures ☐ Eye gaze

Home Environment and Family History

Child lives with: Please select all that apply.

☐ Birth Mother ☐ Birth Father ☐ Step-Mother ☐ Step-Father ☐ Foster Mother ☐ Foster Father

☐ Grandmother ☐ Grandfather ☐ Legal Guardian: please specify _____

☐ Other relative please specify _____ ☐ Siblings (please list sibling ages _____)

Additional Comments: _____

Father's Age: _____ Did he have any developmental delays, speech problems, or special learning problems? Yes No
If yes, please describe: _____
_____

Mother's Age: _____ Did she have any developmental delays, speech problems, or special learning problems? Yes No
If yes, please describe: _____
_____

Adoption: ☐ Yes ☐ No Age at adoption: _____ Additional details: _____
_____

Do any relatives or persons in the immediate family have any of the following? If yes, who?

Neurological Disease	☐ Yes	☐ No	_____
Seizures (Epilepsy)	☐ Yes	☐ No	_____
Hearing Problems	☐ Yes	☐ No	_____
Vision Problems	☐ Yes	☐ No	_____
Emotional Problems	☐ Yes	☐ No	_____
Learning Issues	☐ Yes	☐ No	_____
Hyperactivity	☐ Yes	☐ No	_____

Accessibility

# of stairs to get into home: _____ Handrail? ☐ Right ☐ Left ☐ None
Ramp to get into home? ☐ Yes ☐ No
# of stairs inside of home: _____ Handrail? ☐ Right ☐ Left ☐ None
☐ Bathroom on Main level ☐ Bedroom on Main level
☐ Bathroom on Upper level ☐ Bedroom on Upper level
Comments: _____
_____

Equipment presently used: Please check all that apply.

Equipment	Approximate age	Details	Uses at home	Uses at school/daycare
Braces				
Walker				
Stander				
Manual Wheelchair				
Power Wheelchair				
Hoyer Lift				
Weighted Vest				
Hand Splints				
Track System				
Hearing Aids				
Other:				
Other:				

Describe any home program provided by another provider/doctor/therapist that is currently performed by you (e.g. stretching, strengthening, brushing, etc.) _____
_____
_____

Describe any community groups or sports activities the child is involved in: _____
_____
_____

School and Therapeutic History

Grade in school: _____ Name of school: _____
Teacher(s) Name(s): _____
Does your child have an IFSP? ☐ Yes ☐ No
Does your child have an IEP? ☐ Yes ☐ No

Therapy Services	**Type** (individual or group)	**Status** (ongoing, not started, discontinued)	**How often per week?**	**Where?** (clinic, school, home, etc.)
Assistive Technology				
Audiology				
Behavior Therapy / ABA				
Developmental Therapy				
Early Intervention Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Speech-Language Therapy				
Developmental Follow-up Clinic				
Other:				

Additional comments: _____
_____
_____
_____
_____
_____
_____
_____
_____