Chan Soon-Shiong Medical Center at Windber

Account: V_____ **MRN: M**_____

Patient Name: _____

Date of Birth: _____ **Sex:**_____

Service Date: _____

Attending: _____

CHILD BACKGROUND INFORMATION AND HISTORY

FAMILY INFORMATION

Child's name: _____ Today's date: _____

Birth date: _____ Age: _____ years _____ months

Address: _____

Mother: Name: _____ Age: _____ Occupation: _____

Phone number: Home: _____ Cell: _____

Father: Name: _____ Age: _____ Occupation: _____

Phone number: Home: _____ Cell: _____

With whom does the child live with most of the time? _____

If child is adopted, at what age were they adopted? _____

Siblings:

Name: _____ Age: _____ Health: _____

Name: _____ Age: _____ Health: _____

Name: _____ Age: _____ Health: _____

(Please use other side if additional space is required.)

REFERRING INFORMATION

Who referred your child for an evaluation? _____

What is the reason for referral? _____

When did you first have concerns? _____

What do you see as your child's strengths? _____

In one sentence, how would you describe your child? _____

_____

Do you have any additional information that will help us to better understand your child? _____

_____

What are your primary goals regarding this information? _____

_____

_

Chan Soon-Shiong Medical Center at Windber

Account: V_____ **MRN:** M_____

Patient Name: _____

Date of Birth: _____ **Sex:**_____

Service Date: _____

Attending: _____

SCHOOL HISTORY

Hand preference: _____ Current school placement: _____

Present grade level: _____ What grades, if any, have been repeated? _____

Is your child in a special class or receiving support services? If yes, please specify: _____

_____

INTERVENTION HISTORY

Please check any of the following whom you have contacted concerning your child (include name and contact information if possible):

□ Occupational Therapist _____

□ Physical Therapist _____

□ Speech/Language Pathologist _____

□ Developmental Optometrist _____

□ Behaviorist _____

□ Orthopedist _____

□ Psychologist _____

□ Counseling _____

□ Other _____

MEDICAL HISTORY

Were there any difficulties during pregnancy or delivery? Please specify: _____

_____

Length of pregnancy: _____ Length of labor: _____ Type of birth: □ Vaginal □ Cesarean □ Breech □ Twins or more

Birth weight: _____ Did the baby require assistance in starting to breathe? □ Yes ■ No

Remarks: _____

List any complications/problems in early infancy: _____

List any feeding difficulties in early infancy: _____

Chan Soon-Shiong Medical Center at Windber

Account: V_____ **MRN: M**_____

Patient Name: _____

Date of Birth: _____ **Sex:**_____

Service Date: _____

Attending: _____

Who is your child's present physician? _____

Does your child have a diagnosis? _____

Diagnosed by whom? _____ Date of diagnosis: _____

Does your child have significant health problems, either currently or in the past? Please specify: _____

_____

Please list:

Surgeries: _____

Hospitalizations: _____

Respiratory, lung, or bronchial difficulties: _____

Cardiac problems: _____

Seizures (when and how often): _____

Allergies: _____

Ear infections: _____

Current medications (include reason for each): _____

_____

Previously tried medications: _____

_____

Specialized equipment used: _____

_____

Has your child had a hearing evaluation? □ Yes □ No

By whom: _____ Date of evaluation: _____

Has your child had a vision evaluation? □ Yes □ No

By whom: _____ Date of evaluation: _____

Has your child had a psychological evaluation? □ Yes □ No

By whom: _____ Date of evaluation: _____

Has your child had a neurological evaluation? □ Yes □ No

By whom: _____ Date of evaluation: _____

Chan Soon-Shiong Medical Center at Windber

Account: V_____ **MRN:** M_____

Patient Name: _____

Date of Birth: _____ **Sex:** _____

Service Date: _____

Attending: _____

DEVELOPMENTAL HISTORY

Children sometimes act or appear younger than their chronological age. What age do you think describes your child and why? _____

_____

_____

List the age at which your child accomplished each of the activities below. Indicate "not yet" if they have not yet accomplished the activity.

MOTOR:

Head control	_____	Reaching for objects	_____
Rolling over (both directions)	_____	Finger feeding	_____
Sitting alone	_____	Eating with a spoon	_____
Creeping on all 4s	_____	Using a knife/cutting	_____
Pulling to stand	_____	Drawing a circle	_____
Walking	_____	Cutting with scissors	_____
Jumping	_____	Riding a bike	_____
Hopping on one foot	_____		

Does your child have difficulty learning new motor skills? □ Yes □ No

LANGUAGE:

Spoke first word	_____	Pointing to simple pictures	_____
Combined word	_____	Following one-step commands	_____
Spoke sentence	_____	Following several-step commands	_____
Looking when called	_____	Looks in direction that others point	_____

SELF-HELP:

DRESSING:		GROOMING:	
Putting on shirt independently	_____	Bathing independently	_____
Buttoning independently	_____	Combing hair	_____
Zipping independently	_____	Toilet trained - bowel	_____
Snaps independently	_____	Toilet trained - bladder	_____
Dressing independently	_____	Toileting independently	_____
Tying shoes	_____		

Chan Soon-Shiong Medical Center at Windber

Account: V_____ MRN: M_____

Patient Name: _____

Date of Birth: _____ Sex:_____

Service Date: _____

Attending: _____

Please describe your child as an infant:	YES	NO	SOMETIMES
Cried a lot, fussy, irritable			
Non-demanding			
Alert			
Quiet			
Passive			
Active			
Liked being held			
Resisted being held			
Floppy when being held			
Tense when being held			
Good sleep patterns			
Irregular sleep patterns			

Please describe your child at present:	YES	NO	SOMETIMES
Mostly quiet			
Overly active			
Tires easily			
Talks constantly			
Very impulsive			
Restless			
Stubborn			
Resistant to changes			
Fights frequently			
Usually happy			
Exhibits frequent temper tantrums			
Clumsy			
Difficulty separating from primary caretaker			
Nervous habits or tics			
Falls often			
Wets bed			
Wets or soils pants (how often)			
Has poor attention span			
Frustrated easily			
Has unusual fears			
Rocks self frequently			

Chan Soon-Shiong Medical Center at Windber

Account: V_____ **MRN:** M_____

Patient Name: _____

Date of Birth: _____ **Sex:**_____

Service Date: _____

Attending: _____

Comments: _____

_____

_____

How well does your child do the following?

Sleep: _____

Eat: _____

Toilet: _____

Play: _____

Behave: _____

If and when you discipline your child, what do you do? _____

_____

_____

What do you do that works the best to obtain cooperation from your child? _____

_____

_____

Chan Soon-Shiong Medical Center at Windber

Account: V_____ MRN: M_____

Patient Name: _____

Date of Birth: _____ Sex:_____

Service Date: _____

Attending: _____

FAMILY IMPACT

Please answer the following questions in relation to how things are going for your child and family now. Think about the last month or so (rather than the entire last year or the last day or two). If you child has been sick or has experienced some unusual event (e.g. the last of a long-time caregiver, etc.), try to answer the questions in terms of how things were going just before the event.

Does your child:	**ALWAYS**	**OFTEN**	**SOMETIMES**	**RARELY**	**NEVER**	**NOT APPICABLE**
Play with friends?						
Make and keep friends?						
Relate to being part of the family?						
Interact and play with siblings?						
Interact with parents and other significant adults?						
Communicate needs, wants, and interests effectively?						
"Fit in" with peers?						

How often do the following daily household routines run smoothly for your child and family?	**ALWAYS**	**OFTEN**	**SOMETIMES**	**RARELY**	**NEVER**	**NOT APPICABLE**
Getting ready to go somewhere						
Leaving the house in the morning						
Meal preparation and cleanup						
Mealtimes						
Getting ready for and going to bed						
Bathing and grooming activities						

Chan Soon-Shiong Medical Center at Windber

Account: V_____ MRN: M_____

Patient Name: _____

Date of Birth: _____ Sex:_____

Service Date: _____

Attending: _____

How often do the following daily experiences go smoothly for your child and family?	ALWAYS	OFTEN	SOMETIMES	RARELY	NEVER	NOT APPICABLE
Running errands						
Leaving to go on overnight trips						
Shopping trips for groceries or clothes						
Dining out						
Birthday parties						
Recreational activities, such as bike riding or ball games						
Family outings, such as going to the park, museum, or movies						
Family gatherings, such as holidays, weddings, birthdays						
Vacations						
Spontaneous outings						
Following through with plans (i.e. not having to cancel at the last minute)						
Taking your child with you rather than leaving him or her at home						

Considering your child's special needs, is your family able to:	ALWAYS	OFTEN	SOMETIMES	RARELY	NEVER	NOT APPICABLE
Find and keep a babysitter?						
Socialize with extended family?						
Socialize with friends?						
Stay involved with the community?						
Participate in the neighborhood?						

Chan Soon-Shiong Medical Center at Windber

Account: V_____ **MRN:** M_____

Patient Name: _____

Date of Birth: _____ **Sex:**_____

Service Date: _____

Attending: _____

Comments: (Please include any areas that you think are significant for your family. Use other side if necessary.)

Please describe a typical day for your child from waking until bedtime, including whether it is different for your child to get to sleep at night and stay asleep. (Use other side if necessary.) _____