

PATIENT INFORMATION

Childle Name of			
Child's Name: Current Diagnosis:			
	Grade:		
Reason for Referral:			
Parent/Guardian #1 Name:			
Relationship to Child:	Custody	Custody Status:	
Email:			
Emergency Contact:			
Parent/Guardian #2 Name:	Occı	upation:	
Relationship to Child:	Custody Status:		
Email:			
Who does the child reside with?			
List any medical precautions/allergies/	medications:		
Does your child ever complain of pain?	? If yes, in what area? Please desc	cribe:	

Is your child receiving any other services? (Occupational Therapy, Physical Therapy, Speech Therapy, Special Education, Early Intervention)

Premature (Gestation:weeks) Preeclampsia Full Term Gestational Diabetes Low Birth Weight (lbs) Breast Fed Breech Birth Poor Suction/Latch C-section Birth (Planned)	 Bottle Fed Emergency C-section Multiple Ultrasounds Vaginal Birth Oxygen at Birth Forceps Delivery NICU Stay (Duration:) Vacuum Delivery Other: 	
What (if any) special equipment does your child use?		
WheelchairBracesWalkerCrutches	Eye GlassesHearing AidsCommunication DeviceOther:	
What are your primary areas of concern/What are you	ur goals for therapy?	
MEDICAL HISTORY Please list any significant illness, hospitalizations, etc.:		
Tiedse iist dity significatif iiiriess, fiospitalizations, etc		
Please check all that apply to your child:		
 Chronic Ear Infections Lyme Disease Tubes Abnormal Muscle Tone Tonsils/Adenoid Surgery 	Frequent FeversPoor Weight GainCompromised Immune System	

Please list any significant prenatal or birth history:

DEVELOPMENTAL HISTORY

Please list the approximate age your child was able	to do the following (to the best of your ability):
Lift head while on tummy Started solid food Roll over Held cup Sat without support Toilet trained Crawled	 Fed self Stood alone First single words Walked alone Put words together Ran alone Dressed/Undressed self
Please list any motor development concerns you ho planning, fear of movement, fear of heights, etc.)	ave (i.e. gross motor, fine motor, oral motor, moto
Please list any concerns with feeding/eating or aller	rgies.
Please check all of the following that describe your	child:
 Was placed on belly as an infant Was not placed on belly as an infant Enjoyed belly time as an infant Did not tolerate being placed on belly Met all motor milestones Was late to: Is athletic/plays sports Was/is developmentally delayed SPEECH/LANGUAGE DEVELOPMENT	 Is good negotiating playground equipment Is clumsy Is good with hands (fine motor skills) Avoids climbing, swinging, sliding Handles public places with ease Gets overwhelmed in public places
What is your child's primary mode of communicatio phrases, sentences, augmentative device, picture e	n? (i.e. gestures, singing, single words, short
Please give an estimate of how many words are in y	your child's vocabulary:
Receptive (words understood):	Expressive (words spoken):
How much of your child's speech do you understan	q\$
10% or less 11-24% 25-5	0% 51-74% 75-100%

Are there any sounds your child has difficulty with? Please list:

Does your child demonstrate frustration when not u	nderstood? Y/N
Is your child able to follow 1-2 step directions?	Y/N
Has your child's hearing been checked recently? Results:	Y / N
BEHAVIOR/SOCIAL HISTORY	
Please check all that apply to your child:	
 Is social and engaging Is aggressive Makes good eye contact with others Is oppositional Is well behaved Does not like new places/people Pays attention Does not like crowds Listens well Has difficulty with transitions 	 Plays well with other children Prefers to play alone Does well with change Has difficulty listening/paying attention Understands safety Poor coping skills Takes turn with peers Unable to self-calm Maintains topic Quickly escalates with apparent cause
Please list any behavioral or social concerns:	
What are some of your child's favorite toys/interest	şŞ

EVALUATION & THERAPY SERVICES

Please list any previous therapy evaluations completed with recommendations provided:

Please list any previous psychological/neuropsychological/psych-educational evaluations completed with recommendations provided:

AUTHORIZATION FOR RELEASE OF INFORMATION

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I hereby give permission to Roots to Shoots Pediatric Therapy to discuss, release, or obtain information relative to my child's therapy from the following professionals (i.e.pediatrician, teacher(s), psychologist, developmental optometrist, vision specialists, speech and language therapist(s), physical therapist(s), occupational therapist(s), etc.)

) Pediatrician Name:		
	Phone:	
(2) Teacher Name: _		
	Phone:	
(3) Other Name:		
Address:		
	Phone:	
(4) Other Name:		
Address:		
	Phone:	