Kidz Therapy, LLC
3508 Fort Hill Drive
Alexandria, Virginia 22310
703-862-6557

HISTORY

Thank you very much for taking the time to complete this history. Please answer the following questions as best you can. If there is not adequate space for your comments, please continue to write on the back of this form. Thank you so very much for the privilege to help you help your child!

BIOLOGICAL INFORMATION

Child's Name: ____ **DOB**: __________
Parents' Names: ____
Address: ____
Cell/Home #s: M:______________ **F:**______________ **Primary Home:** ___________
Name of Person completing this form: _____________________________________
Relationship to child: _____________________**Email(s):** ______________________
Siblings:
1. __________________________________ Age: _____ Grade: _____ Gender: _____
2. __________________________________Age: _____ Grade: _____ Gender: _____
3. __________________________________Age: _____ Grade: _____ Gender: _____

Child's primary language: ______________ Secondary: _________________________
What is the primary language spoken in the home? ______________________________
What other languages are spoken in the home? ________________________________

Current concerns/reason for referral:
____
____
____

When was the concern first noticed and by whom?
____

Has the concern/ problem changed since it was first noticed?
____
____
____

Is your child aware of the problem? If yes, how does he or she feel about it?
____
____
____

Describe your child's current demeanor/behavior:
____
____
____

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MEDICAL INFORMATION:
Please circle all that apply and/or fill in the blanks.

Diagnosis: ____

Referring Physician: ____
Physician address: ____
Physician Phone: ____
Physician Fax #: ____
Does your child see other specialist(s)?
Physician:___________________________________**Specialty:**___________________________
Physician:___________________________________**Specialty:**___________________________
Physician:___________________________________**Specialty:**___________________________

Other Professional Providers: (occupational, physical or speech therapy, counseling, tutoring, etc): *please list name and contact number. Also please list previous therapies or services your child has received and the approximate dates s/he received them.*
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Do other family members have any speech, motor, cognitive, or other diagnoses/delays? If yes, please describe:
____
____
____
____

Pregnancy And Birth:
Please circle *Yes* or *No* to the following questions and remark in the space provided.

1. Were there any infections/illnesses during pregnancy? Yes or No
____

2. Were there any drugs or medications taken during pregnancy? Yes or No
____

3. Was there any unusual stress during pregnancy? Yes or No
____
____

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4. Was the pregnancy full-term? Yes or No
Premature delivery? Yes or No If yes, weeks gestation? __________

5. Was the labor normal? Yes or No____
____

6. Was the delivery normal? Yes or No (Explain ex: Cesarean section, breech, sideways, cord around neck, forceps used) ____
____

7. Was medication given during delivery? Yes or No
____

8. Were there any other complications during the pregnancy? Yes or No
____
____

9. What was the child's weight at birth? _____________ Apgar Scores: 1 min_____ 5 min _______

10. Were there any complications (ie. seizures, jaundice, congenital defects other): Yes or No
____
____

11. Was there a need for: oxygen, transfusions, tube feedings, other: _________________________
____

12. Did your infant cry right away?____

13. What was the length of the infant's hospital stay? ___________________________________

14. Was your child breastfed or bottle-fed? How long? ___________________________________

15. Did the infant have any feeding problems? ____
____

16. Please state any other difficulties or special cares: ___________________________________
____

History of Major Illnesses:
If applicable, provide approximate age at which the child had the following illnesses/conditions:

High Fever (above 103.5 F): ___________
Pneumonia: ___________

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Meningitis: ___________
Seizures: ___________
Chicken Pox: ___________
Headaches: ___________
Mastoiditis: ___________
Tonsillitis: ___________
Other: ____

History of hospitalizations:
____
____
____
____

History of ear infections: Yes or No; If yes, how many: ____________________________________

Tonsillectomy and/or adenoidectomy: Yes or No ____

When was your child's most recent hearing exam? ________________ Results: ________________

Is child currently on medication for ear infection? Yes or No ______________________________

Are there any diagnosed mental, physical or emotional disabilities? Yes or No _________________
____

Are there any concerns about physical, sexual, mental or emotional abuse? Yes or No ____________

Were any of these conditions chronic? If so, which ones and how often did they occur?
____
____

Current Health:
Current weight: _______________ Current height: _________ Head circumference: ____________

Date of last physical exam: _____________ Results: ______________________________________

Current Medications/Dosage/Frequency:____
____

Known Allergies: Yes or No If yes, please list:____
____

Food Allergies/Restrictions: ____

Are immunizations up to date: Yes or No ____

Sleep Schedule:

My child currently sleeps/naps (circle one): inconsistently well restless other
Bedtime: _________________ Duration: _________________ Wakes at: ____________________
Naps/day: ______ Nap time(s) of day: _________________ Duration: ______________________

DEVELOPMENTAL HISTORY

1. Do you feel that your child met his/her developmental milestones on time when compared to peers or siblings?____
____
____

2. Does your child appear to participate in age appropriate movement activities (i.e. riding a bike, skipping, etc.) ____

3. Do you have concerns or questions about his/her development?__________________________
If yes, please explain:____
____

4. Describe your child's demeanor and behavior as an infant:______________________________
____

5. Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, distracted by sounds, etc.):
____
____

6. What do you see as your child's strengths?____
____
____
____
____

Developmental Milestones:

Please list the age that your child did the following and answer questions below (in months).

Skills	Age in months	Not achieved yet
Roll		
Sit		
Belly crawl		
Crawl on hands/knees		
Walk		
Run		

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Skip		
Said first word		
Finger fed		
Used spoon		
Drank from cup		
Dressed independently		
Used the toilet independently		
Bladder control		
Bowel control		

Used single words (e.g., no, mom, doggie, etc.): Yes or No

Combined words (e.g., me go, daddy shoe, etc.): Yes or No

Used simple questions (e.g., Where's doggie? etc.): Yes or No

Engaged in a conversation: Yes or No

How well do **you** understand your child's speech? ____
In context: _____% of the time; out of context_____% of the time.

How well do **others** understand your child speech? ____
In context: ___% of the time; out of context___% of the time ________________________

Self Help Skills:

1. Does your child resist having his/her:
Teeth brushed? Yes or No Hair brushed? Yes or No Face washed? Yes or No
____
____

2. Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, gagging, aspirating, etc.)? If yes, describe:
____
____
____

3. Is your child a picky eater? If so, what texture/temperature preferences have you observed?
____
____
____

4. My child currently eats/drinks at: (circle one for each choice)
- Regular or irregular intervals
- Consistent or inconsistent amounts

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5. Check applicable box for level of assistance needed for each activity of daily living.

ACTIVITY	Independent	25% Help	50% Help	75% Help	100% Help
Toileting					
Sits on potty					
Wipes self					
Washes hands					
Dries hands					
Bathing					
Gets in/out of tub/shower					
Washes hair					
Washes body					
Washes face					
Dries self					
Brushes teeth					
Combs/Brushes hair					
Dressing					
T-shirt					
Pants/shorts					
Socks					
Shoes					
Lace shoes					
Velcro shoes					
Dresses in a timely manner					
Selects own clothes appropriate for season					
Feeding					
Uses cup					
Uses spoon					
Uses fork and knife					
Oral Motor		Yes	No	Some	
Chews with closed mouth					
Swallows food with no gagging					
Overstuffs mouth					
Eats a variety of foods and textures					

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SOCIAL/EDUCATION HISTORY:

School/Day Care: ______________________________ Grade: _______________________________

Teacher's Name: _______________________________ Phone: _______________________________

How is your child doing academically (or pre-academically)?_________________________________
____

Does your child receive special services in school? If yes, describe:__________________________
____

Activities your child enjoys:____
____

Does your child prefer to do these activities alone or with other children/siblings? _____________
____

Are there any cultural or religious beliefs that you would like us to be aware of and/or take into consideration when we are working with your child? ______________________________________
____
____
____
____
____

PLEASE USE SPACE BELOW FOR ANY ADDITIONAL COMMENTS:

____
____
____
____
____
____
____
____
____
____
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