

## THE ENRICHMENT CENTER AT ADVENTURE WORLD

### CHILD HISTORY FORM- revised 01/2010

The information you provide us with will help us develop a sense of who your child is and how you, as a parent, experience your child. This helps us to know more about what we need to ask you as well as helps us develop appropriate assessment and intervention plans, as necessary. Thank you for taking the time to be thorough!

Child's Name:

Today's Date:

Date of Birth:

Age:

School:

Teacher:

Reason for contacting our office:

Current Diagnoses (of any kind):

Recommendation from other professional(s)/parent(s)?

What concerns were shared with you and by whom?

#### **Medical History Prior to Birth Circle: Comments:**

Were there any illnesses, injuries, surgeries, or prenatal difficulties? Yes No

Was delivery: Vaginal Breech Caesarian Other: Please specify

Were forceps or suctioning used? Yes No

What was the child's birth weight?

Were there any complications following birth?

(respiration, transfusions, tube feeding) Yes No

Was the newborn hospitalization unusually long? If so, why? Yes No

Were there any feeding difficulties as an infant? Yes No

Has your child had any significant childhood illnesses?

If so, please explain. Yes No

Has your child had any significant physical injury?

If so, please explain. Yes No

Has your child been treated for any physical medical problems?

If so, please explain. Yes No

Does your child have any allergies, food sensitivities, dietary restrictions? If so, please specify.

Yes No

Does your child have frequent ear aches or ear infections?

Yes No

Does your child have PE tubes in his or her ears? If so, have they been replaced?

Yes No

Does your child seem to hear but not clearly understand what is said to him or her?

Yes No

Have you had your child's hearing tested?

Yes No

Does your child wear glasses? If so, what is the correction for?	Yes	No
Is your child currently taking any medications? If so, please list.	Yes	No
Has your child had their recommended immunizations?	Yes	No
Has your child had toxicity testing?	Yes	No
Does your child use any adaptive equipment? If so, what?	Yes	No

Does your child use any home therapy equipment (trampoline, swing, brushing)? If so, please specify. Yes No

Does your child have sensory needs or sensory defensiveness to touch, sound, texture, odors, or level of stimulation?  
Yes No

**Developmental History**

**At what age did your child do the following milestones?**

Approximate age:  
 Roll over from stomach to back and back to stomach?  
 Sit independently?  
 Crawl?  
 Walk?  
 Speak his/her first word? What was it?  
 Combine words?  
 Speak sentences?  
 Drink from a cup independently?  
 Feed self with a spoon independently?  
 Dress self independently?

Describe your child at present by circling characteristics that most closely fit him or her:  
 Is mostly quiet  
 Is overly active tires easily talks constantly  
 Impulsive is restless is stubborn over reacts  
 Is resistant to change is usually happy fights frequently has difficulty separating from primary  
 Caretaker  
 Is clumsy,  
 Other  
 describe: \_\_\_\_\_

\_\_\_\_\_  
 Falls often wets bed is easily frustrated has unusual fears  
 Rocks self frequently has difficulty learning new tasks (riding a bike, writing)  
 Has frequent temper tantrums, describe:  
 \_\_\_\_\_

Have any nervous tics or habits, describe:

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**Speech and Language History:**

Please describe the concerns you have regarding your child's speech and/or language development and give examples if you can.

How does your child make his/her wants and needs known?

Does your child play with toys differently from other children his or her age? Explain.

Do you have concerns with how your child interacts and communicates socially?

Yes No

Does your child have special interests that he/she knows a lot about and seems to want to talk about at length often to the exclusion of other topics and without regard to the listener?

If so, what is/are the special interest(s)

Yes No

Does your child have difficulty understanding nonverbal communication (facial expressions, gestures, physical space, and tone of voice) or seem unaware of those communication cues?

If your child is on an IEP, IIP, or IFSP please describe their current speech and language goals.

**Family History**

Does anyone in your family have a history of speech, language, or learning difficulties? If so, please explain who and their relationship to this child.

Is there a family history of related medical diagnoses (physical or emotional)? If so, please explain.

**Goals:**

I would like to see my child be able to:

Examples: speech/language (ex "talk clearly, use more words, And follow directions. . .")

occupational therapy (ex "dress independently, tolerate more sensory experiences, and use his /her hands better...")

What does your child like to do?

What does your child dislike?

Has your child received therapy services in the past? If so, where and may we have copies of those reports?

**Thank you again for taking your time for filling out this child health form!**