

School History

Does your child attend: daycare pre-school elementary middle high school grade level _____

Name of school: _____

Repeated grades: _____

Exceptional education programs: _____

Teacher's name: _____

Have any learning problems been identified: _____

Academic areas of concern: _____

Will your child be starting daycare or preschool any time soon: _____

Behavior/Social/Motor History

Please mark if your child:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> avoids speaking | <input type="checkbox"/> withdraws from others | <input type="checkbox"/> walks on tip toes | <input type="checkbox"/> is sensitive to noises |
| <input type="checkbox"/> is aggressive | <input type="checkbox"/> does not play well | <input type="checkbox"/> falls frequently | <input type="checkbox"/> does not follow directions consistently |
| <input type="checkbox"/> is frustrated/angry easily | <input type="checkbox"/> cries easily | <input type="checkbox"/> hits her/him self | <input type="checkbox"/> dislikes certain textures of foods or clothes |
| <input type="checkbox"/> does not like to be touched | <input type="checkbox"/> is destructive | <input type="checkbox"/> is hyperactive | <input type="checkbox"/> coughs/chokes on food |
| <input type="checkbox"/> is distractible | <input type="checkbox"/> eats poorly | <input type="checkbox"/> seems awkward/clumsy/uncoordinated | |
| <input type="checkbox"/> does not chew foods | <input type="checkbox"/> forgets easily | | |
| <input type="checkbox"/> spits up frequently | | | |

Home Environment

Are there any family concerns that would help us understand your child better? _____

What types of activities/toys does your child enjoy? _____

Where and with whom does your child spend most of his/her time? _____

List your child's strengths: _____

List your child's weaknesses: _____

Please complete the following section if your child is exposed to more than one language:

- | | | | |
|---|----------------------------------|----------------------------------|---------------------------------------|
| What language is primarily spoken at home: | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other: _____ |
| What language do the parents speak to each other: | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other: _____ |
| What language do the parents speak to this child: | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other: _____ |
| What language does the child seem to prefer: | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other: _____ |

Speech and Hearing

At what age did your child:	Begin babbling _____	Speech/language seem to stop/regress _____
	Gesture _____	Respond to name _____
	Speak in sentences _____	Follow simple directions _____
	Say first word _____	Put 2-3 words together _____

- How does your child communicate his/her needs:
- | | | |
|-----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> eye gaze | <input type="checkbox"/> pointing | <input type="checkbox"/> vocalization |
| <input type="checkbox"/> words | <input type="checkbox"/> sign | <input type="checkbox"/> sentences |
| <input type="checkbox"/> crying | <input type="checkbox"/> speech | <input type="checkbox"/> head nodding |

Does your child have any allergies to medications: No Yes. If yes, please list: _____
 Does your child have any allergies to foods: No Yes. If yes, please list: _____
 Is your child allergic to latex: No Yes.

Falls Risk Assessment

Is your child an independent walker? Yes No

If no, does your child use any of the following:

- wheelchair hand held assist
 cane or walker furniture / wall
 child does not walk

Does your child have any balance problems? Yes No

If yes, please describe: _____

Is falling a problem for your child? Yes No

If yes, is this a new problem? Explain: _____

Health Insurance Portability Accountability Act

We may be calling to remind you of:

- ❖ Appointments/cancellations/rescheduling
- ❖ Verify your personal health information
- ❖ Any supplies/medical equipment ordered is ready for pick up

If you are not available, we will be leaving a detailed message at (please indicate):

- Work – list phone number: _____
 Home – list phone number: _____
 Other - list phone number: _____
 E-mail address: _____

NO - please do not leave any messages.

Thank you for taking the time to complete this form! We hope to make this a positive experience for you and your child.