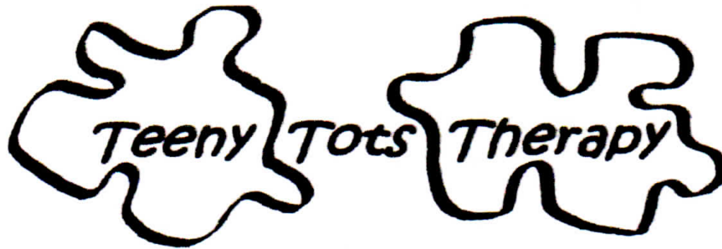

Form Completed by________________________ Date:________________________________

Referral and Background Information:

Childs Name________________________Parents______________________________________
Siblings (Name and ages)____
Address____
Email Address and Phone #:____
Physician(name and address)____
Date of Birth________________________Diagnosis__________________________________
Reason for and referred by____

Please circle responses that apply and provide details

History:

Mother's pregnancy: Normal Uneventful Illnesses______________________
Medications during pregnancy Yes No ______________________
Full term Premature How many weeks______________________
Pregnancy Complications Yes No ______________________
Vaginal Cesarean Section Reason______________________________
Forceps Suction Breech Face Presentation
Jaundiced under lights at home under lights in hospital # days____________
Cord around neck yes no
Birth Complications Yes No ______________________________
Required additional Hospitalization Yes No # days/reason ____________________
Apgar scores 1Minute_________ 5 Minutes_________
Birth Injuries____
Birth Weight________________________

Milestones:

Sat alone # months _____________ Crawled # months___________ usual manner/commando
Walked # months_____________
Early Words # months__________ Phrases/Sentences # months ____________________
Responds to their name Yes No Gives eye contact Yes No
Appears interactive (smiles "coos") Yes No
Nursed Bottle Fed Any difficulties ________________________________
Ear Infections Yes No PE Tubes placed Yes No ____________________
Seizures Yes No Allergies Yes No
Medications____

Major concerns of parent/teacher/caregiver:_____________________________________
____

Received Occupational Therapy previously Yes No Duration and Frequency____________
Received Physical Therapy previously Yes No Duration and Frequency____________
Received Speech Therapy previously Yes No Duration and Frequency____________

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