New Patient Information Form

Date: _____

Patient Information:

Child's Name: _____

Child's Date of Birth: _____ **Age:**_____ **Child's Gender:** ☐ **Male** ☐ **Female**

Child Goes By: _____

Child's diagnosis code(s): _____

Parent/Guardian Information:

Parent/Guardian #1 Name: _____

Parent/Guardian #2 Name: _____

Please Indicate: ☐Single ☐ Married ☐Separated ☐ Divorced

Who has legal guardianship of the child? _____

Will someone, other than the parent(s), typically bring or pick up your child to/from the clinic?

If so, who: _____

Relationship to child: _____

Contact Information: _____

Emergency Contact (grandparent, neighbor, relative, etc.)

Name: _____ Relationship: _____

Phone: _____

Medical History:

Where was the child born (city, state and hospital)? _____

Was this child adopted? ☐ Yes ☐No

If Yes, please give what age and from where: _____

Does this child have siblings? ☐ Yes ☐No

If yes, please give name and ages:

Type of birth: ☐ Single ☐Twin ☐ Triplet ☐Other _____

Mom's health during pregnancy: ☐Good ☐ Fair ☐Poor

Did the Mother?	**Yes/No**	**If yes, please explain.**
Have any infections/illnesses?		
Have any unusual stress during pregnancy?		
Take any medications during pregnancy?		
Have any infertility issues?		
Were drugs, alcohol and/or tobacco used during the pregnancy?		
Was the birthing process abnormal? (e.g. breech)		

Type of delivery: ☐ Vaginal ☐ C-section ☐ Forceps ☐Vacuum Extraction

Was the delivery an emergency? ☐ Yes ☐ No

Any complications? _____

Was the child carried to full term (37 weeks to 42 weeks)? ☐ Yes ☐ No **Number of weeks:** _____

***If pre-mature**, how early*? _____

Length of time spent in NICU? _____

Is the cause known? _____

Birth weight: _____ **lbs.** _____ **oz.**

If the infant was hospitalized, what was the length of stay?	
Was there a need for oxygen/ventilator, transfusions, or tube feedings?	
Jaundice? Light therapy? How long?	
Brain hemorrhage?	

Cyanosis, Congenital defect, apnea/bradycardia?	
Failure to progress?	

Child's general health: ☐Good ☐Fair ☐Poor

Is your child immunized? ☐Yes ☐No

If no, please explain: _____

Are immunizations up-to-date? ☐Yes ☐No

If no, please explain: _____

Has your child had a vision test?

If yes, when? _____ By whom?_____

Results:_____

Has your child had a hearing test?

If yes, when?_____ By whom?_____

Results:_____

Has your child had any of the following? Please explain.

Serious illness?	
Cardiac problems?	
Respiratory problems?	
Asthma?	
Allergies?	
Gastro-intestinal problems?	
Injuries?	
Congenital Abnormalities?	
Surgery?	
Ear infections/tubes?	
Seizures?	
X-rays, CT Scans, MRI, or EEG? Include Results	
Genetic Testing? Include Results	
Other (disease, chronic illness, etc.)	

Allergies:

Allergies to Medications? ☐Yes ☐ No

Please List: _____

Allergies to Food? ☐Yes ☐ No

Please List: _____

Special Diet? ☐Yes ☐ No

Please List: _____

Allergies to Environmental/Respiratory Agents? ☐Yes ☐ No

☐Pollen ☐Dust ☐ Food ☐Animal -Type: _____

☐Other: _____

Please list any medication(s) your child is currently taking, it's purpose and frequency of dosage.

Medication	Purpose	Dosage	When Taken

Please list any medication(s) your child has received in the past.

Medication	Purpose	Dosage	When Taken

Are there any medical precautions the therapist should be aware of when working with your child? Please list and describe: _____

_____

Does your child have any assistive devices (glasses, orthotics, wheelchair, hearing aids, communication devices, etc)? _____

Is there a history of learning difficulties, developmental delays, attention issues, mental health disorders and/or genetic disorders in your family? _____

_____

Developmental History and Current Functional Status:

Please give approximate ages if remembered, or comment on anything unusual.

Rolling over		Walk		Say words	
Sit up		Chew solids		Say sentences	
Belly crawl		Drink from a cup		Crept on hands and knees	
Pulled up to standing		Cruising (held onto objects to walk)		Feed independently	
Dress/undress self with assistance		Bathe self/assist with bathing			

Was the crawling phase brief or absent? ☐Yes ☐No

Is your child toilet trained? ☐Bladder ☐Daytime only

☐Bowel ☐Daytime only

Was your child, as an infant (check all that apply)

☐Fussy/irritable ☐Floppy when held

☐Non-demanding ☐Tense/stiff when held

☐Irregular sleep patterns ☐Liked being held

☐Over-active, never still unless sleeping ☐Difficulty or disliked being on stomach

Check which describes your child at present:

☐Mostly quiet ☐Relaxed/patient ☐Tires easily

☐Too Impulsive ☐Stubborn ☐Over-reacts

☐Usually happy ☐Wets bed ☐Overly-active

☐Poor attention span ☐Rocks self frequently ☐Aggressive

☐Has difficulty separating from primary caregivers ☐Has nervous tics/habits ☐Talks constantly

☐Restless ☐Resistant to change ☐Fights frequently

☐Clumsy/falls often ☐Easily frustrated ☐Cries often

☐Cries infrequently ☐Exhibits frequent temper tantrums

☐Has difficulty learning new tasks

Feeding:

Were there any feeding difficulties at birth?

As a newborn, did the child have good sucking ability?

Was the child: ☐bottle fed ☐breast fed ☐both

At what age was the child weaned?

Currently eats? ☐Baby food ☐junior food ☐mashed table food ☐table food

☐Drinks from cup independently ☐finger foods ☐uses spoon ☐uses fork

☐uses knife

Does your child have food preferences? _____

Does your child avoid certain textures or flavors? _____

Describe your child's self-feeding behaviors. _____

Sleeping:

Does your child have regular sleep patterns? ☐Yes ☐ No

If no, please describe. _____

Wake frequently through the night? ☐Yes ☐ No

Does your child move around in their bed/crib through the night? ☐Yes ☐ No

Tend to be an early riser? ☐Yes ☐ No

Have difficulty falling asleep? ☐Yes ☐ No

Where does your child sleep? _____

Does your child have a routine for going to sleep? ☐Yes ☐ No

If yes, please describe. _____

Does your child snore? ☐Yes ☐ No

School Skills:

School Name: _____

Teacher: _____ Grade: _____

What is your child's favorite subject? _____

What is your child's least favorite subject?_____

Describe teacher's concerns. _____

_____

Is your child considered to have difficulty in any of the following (check all that apply)?

☐Reading ☐Following directions ☐Restlessness

☐Math ☐Finishing a task ☐Handwriting

☐Spelling ☐Paying attention ☐Organizing work

☐Other:_____

Presenting Problems:

What are your concerns?

Academic:	
Activities of daily living: e.g eating, dressing, sleeping	
Relationships:	
Sensory:	
Motor:	
Play:	
Speech:	
Other:	

Interests/strengths:

What are your child's gifts/strengths?	
What kind of interests and activities does your child have? (toys, hobbies, sports, clubs)	
What else should we know about your child to make a connection?	

What are your goals/your child's goals for therapy? Be as specific as possible.
