FIT-N-WISE
A Wise Health System Service

PEDIATRIC THERAPY

Date _____

Child's name_____ Birthdate _____ Gender_____

Primary Care Physician_____ Neurologist _____

Orthopedist _____ Other Specialists _____

Home Phone_____ Cell Phone_____

Email_____ Preferred method of contact _____

Parent/Guardian's Names _____

Is your child in pain today? YES / NO If yes, where is your pain?_____

Describe your concerns regarding your child's development (gross/fine motor and communication):

_____

_____

When was the problem first noticed? _____ Does your child receive therapy at school? _____

Has your child ever been evaluated or treated by a therapist before? YES / NO

If yes, please describe the therapy and the results of the evaluation or treatment:

_____

What do you hope to gain from this evaluation?

_____

Growth and Developmental History

Please tell us the approximate age your child did the following:

Sit alone _____
Crawl _____
Walk alone _____
Bladder control _____
Bowel control _____
Follow simple commands _____
First word _____
Combining 2 or more words _____

Medical and Social History

Please check any of the following that apply to your child:

- ☐ Complications during pregnancy or delivery
- ☐ NICU at birth
- ☐ Feeding deficits/ difficulty gaining weight
- ☐ Hospitalizations (other than birth)
- ☐ Ear infections/ PE tubes
- ☐ Fractures
- ☐ Seizures
- ☐ Respiratory problems
- ☐ Allergies
- ☐ Asthma
- ☐ Physical disability
- ☐ Brain injury (Concussion, TBI, CHI)
- ☐ Tumors
- ☐ Other _____

Has your child ever been diagnosed with the following?

- ☐ ADD/ADHD
- ☐ Auditory Processing Disorder (APD)
- ☐ Down Syndrome
- ☐ Autism Spectrum Disorder
- ☐ Mental Retardation
- ☐ Cerebral Palsy
- ☐ Cranial Facial Abnormalities
- ☐ Other _____

List any major surgeries and/or hospitalizations:

_____

_____

Have any of the following diagnostic tests been performed?

XRAY Date: _____ Body Area: _____ Results:_____

MRI Date:_____ Body Area: _____ Results:_____

Modified Barium Swallow Date:_____ Results:_____

Genetic Testing Date: _____ Results: _____

Please list allergies (medications or food) _____

Please list prescriptions your child is currently taking and the reason why they were prescribed.

_____

Please list all family members that live with the child (include the ages of siblings).

_____

Please list all languages that are spoken within the home:_____

Does your child attend a preschool / day care program? YES / NO

Has your child ever had a hearing evaluation? YES / NO

Results_____

Communication Checklist – Please check any of the following that describes your child:

- ☐ Does not produce certain sounds (please list): _____
- ☐ Does not communicate as well as other children his/her age
- ☐ Cannot be understood as well as other children his/her age
- ☐ Does not appear interested in communicating with other children
- ☐ Does not communicate as well as he/she used to
- ☐ Does not initiate conversations with familiar people
- ☐ Becomes frustrated easily
- ☐ Has difficulty controlling behavior
- ☐ Has difficulty swallowing
- ☐ Refuses many foods and textures (please list): _____

Educational History – Please complete if your child is school age.

Does your child attend public, private, or home school? _____
Name of School _____ Grade_____
How would you describe your child's school achievement? (grades, social skills, etc)
_____
Has your child ever been held back for any reason? YES/NO _____
Does your child attend therapy at school (speech, occupational, or physical)? YES / NO
If yes, please describe the frequency, type, and goals for therapy at school:
_____
_____
_____
Does your child receive any accommodations at school? _____
Does your child have an Individualized Education Plan (IEP)? _____
What subjects are easy for your child? _____
What subjects are difficult for your child? _____
Does your child's communication limit his/her success at school? _____
Does your child have difficulty making friends? _____
Does your child exhibit any behavior issues at school? _____

Equipment- Please check any equipment your child has at home.

- ☐ Wheelchair
- ☐ Braces/ AFOs
- ☐ Walker
- ☐ Standing Frame
- ☐ Other _____

Sensory Checklist – Please check the behaviors below that apply to your child:

Infants/Toddler

- ☐ Difficulty falling asleep or staying asleep
- ☐ Seems uncomfortable in clothes
- ☐ Rarely plays with toys
- ☐ Floppy body
- ☐ Difficulty shifting focus from one activity to another
- ☐ Resist cuddling

Pre-School/School Age

- ☐ Needs a long time to learn a new skill
- ☐ Appears clumsy, not keeping up with peers
- ☐ Unpredictable behavior in social situations especially new ones
- ☐ Acts restless
- ☐ Short attention span
- ☐ Gets upset with routine changes
- ☐ Acts impulsive or angers easily (Difficulty making friends)
- ☐ Exhibits "picky" eating behavior
- ☐ Seems weak prefers sedentary activities
- ☐ Appears to not understand verbal instructions
- ☐ Difficulty reading
- ☐ Misinterprets questions

Fine Motor/Visual Perceptual/Self-Help (Pre-K and School Age)

- ☐ Unable to hold crayon/pencil within fingers
- ☐ Unable to make marks on paper
- ☐ Unable to manipulate toys
- ☐ Difficulty cutting/coloring/writing
- ☐ Unable to pick up small objects with fingers
- ☐ Difficulty dressing/undressing
- ☐ Difficulty using toilet
- ☐ Difficulty using fork/spoon
- ☐ Difficulty catching ball
- ☐ Difficulty climbing on playground equipment

**** Please write any additional information that we need to know on the back of this form ****