Speech Center of katy with BRIDGING THE GAP | PEDIATRIC OT

2024 Pediatric Client History

Please fill out the information in this form to the best of your knowledge. If you have any previous evaluations or reports that you feel would be helpful, please bring them to your first evaluation. Paperwork is required to be submitted prior to the evaluation.

Your appointment is scheduled with: _____

Patient's Full Name: _____

Birth Date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Email Address: _____

Diagnosis (if any): _____

ICD-10 Diagnosis Codes: *(codes will be used for insurance billing)*

_____

_____

Referred by: _____

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Family Information

Father or Caregiver's Name: _____

Relationship to the Child:

☐ Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other

Father/Caregiver's Employer: _____

Mother / Caregiver's Name: _____

Relationship to the Child:

☐ Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other

Mother/Caregiver's Employer: _____

If both primary caregivers work, who cares for the child? _____

Address: _____

Phone Number(s): _____

When is the client in this childcare facility? _____

Predominant Language Spoken in the Home:_____

Family History

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Names, ages of brothers and sisters: _____

_____

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_____

_____

Is there a history of speech, language, and/or hearing problems in other family members? If so, please describe:_____

_____

_____

_____

Are there any family stressors that may impact the child's behavior?

	NO	YES	EVENT	EXPLANATION
1			Marital separations or divorces	
2			Death in the family	
3			Financial crisis	
4			Job change / difficulties	
5			Problems at school	
6			Legal problems	
7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event(s)	

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Child's Birth History

1. City, State & Hospital where the child was born: _____

_____

2. Pediatrician's Name: _____

3. Gestational Age at time of delivery (or # weeks early or late) Type of Delivery:

_____

4. What were the baby's APGAR scores? 1 min _____ 5 minutes _____

5. Birth Weight: _____ Birth Length: _____

6. When was the Mom and Baby Discharged? _____ Any time in NICU? Why?
_____

7. What was the condition of the infant while in the nursery? Please indicate by placing a checkmark in the "NO" or "YES" column and explain what month, why, what, what occurred, how treated, etc.

	NO	YES	DESCRIPTION	EXPLANATION
1			Was blue / cyanotic at birth	
2			Required stimulation to breathe	
3			Required oxygen at birth	*How much / what type?*
4			Required resuscitation	
5			Was considered small for gestational age	
6			Had tremoring or seizures	*Which / for how long?*
7			Very low tone	

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8			Brain hemorrhage	

9			Anemia and/or transfusions	*Which / how many times?*
10			Jaundice (yellow coloring)	*How much / how treated?*
11			Had bruising	
12			Rh incompatibility problems	
13			Infections	
14			Congenital birth defects	
15			Aspiration (meconium or fluid)	*Which / how treated?*
16			Respiratory distress signs or syndrome	
17			Needed ventilation	*What type / how long?*
18			Choking or vomiting episodes	
19			Tube feedings	
20			Needed medications	

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Medical History

It is very important to have as complete a medical history for the client as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include the client's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent colds/respiratory illness	
2			Frequent strep/sore throat	
3			Frequent ear infections (tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Kidney/renal disorder	
9			Urinary problems/infections	
10			Hormonal problem	
11			Muscle disorder/problems	
12			Joint or bone problems	
13			Skin disorder/skin problems (eczema)	
14			Vision disorder/problems	
15			Eye infections	

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16			Neurological disorder	

17			Seizures or convulsions	
18			Stomach disorders/pain	
19			Vomiting/digestion problems	
20			Failure to gain weight or feeding problems	
21			Constipation/diarrhea	
22			Dehydration episodes	
23			Hearing loss	
24			Head injuries or concussions	
25			Ingestion of toxins, poisons, foreign objects	
26			Major medical procedures (detail below)	
27			Chronic medications (For what and when?)	
28			Any major childhood illness (pox, croup, measles, mumps, meningitis etc.)	

Hospitalizations / Surgeries: Dates & Reasons

1. _____

2. _____

3. _____

4. _____

Allergies

_____

_____

_____

_____

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Present Health Status

Most recent Height: _____ Weight : _____ Date: _____

Note any illnesses for which the child is currently being treated, including current medications:

_____

_____

Feeding History

1. Please explain, in your own words, the client's current feeding problem (if any):

_____

_____

_____

2. Was the client breast fed?_____From when to when? _____

Was the client bottle fed?_____From when to when? _____

Please describe the client's initial skill on the breast and/or bottle: _____

_____

_____

3. During these early feedings did the client frequently arch, cry, spit up, gag, cough, vomit or pull off of the nipple? Describe behaviors you saw, when they would happen, why and for how long:

_____

_____

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4. How was the weaning process from the breast and/or bottle, and why the client was weaned:

_____

_____

5. What age did the child transition from baby to cereal?_____Baby food? _____

Finger food?_____ Full transition to table food _____

How were these transitions were handled by the child, especially if any difficulties occurred:

_____

_____

_____

6. Has the client ever been on any type of special diet (other than previously described)?

_____

If yes, please describe the type of diet, at what ages, why, and the client's response:

_____

_____

_____

_____

Developmental / Social History

Indicate the age when the client first performed each of the following INDEPENDENTLY. If you can not recall or find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If the client has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

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MILESTONE	AGE	EARLY	ON TIME	LATE	GOOD/FAIR	POOR
Smiled						
Held head up						
Rolled over						
Reached for an object actively						
Transferred object between hands						
Sat unsupported						
Crawled						
Stood alone						
Walked by himself/herself						
Said first words						
Threw objects actively						
Ran by himself/herself						
Followed simple one-step directions						
Said 2-3 word phrases						
Ate unaided with a spoon/fork						
Dressed by himself/herself						
Rode bicycle without training wheels						
Caught a thrown object						
Demonstrated handedness (which hand?)						
Knew colors						
Counted to 5						
Knew alphabet						
Potty trained						

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1. Do you feel the child was “faster” / “slower” than his/her peers in other ways? Please explain:

_____

2. If in school, please describe any difficulties or strengths in reading, writing or spelling:

_____

3. Name of previously attended schools:

School: _____ Grade(s): _____

School: _____ Grade(s): _____

School: _____ Grade(s): _____

4. Name of current school: _____ Grade: _____

Address:_____Phone: _____

Any special education services (which, when)? _____

Teacher: _____

What comments have other adults, e.g., teachers, made about the child’s speech / language?

_____

5. How does the client relate to peers? _____

_____

_____

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6. Compared to other children of similar age, how would you describe the client's overall behavior and ability to listen to and follow directions? _____

_____

7. Has the child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
8			Aggression / destructiveness	
9			Nervous habits (nail biting, etc.)	
10			Masturbation	
11			Major mood swings	
12			Under or over-reactive to sounds	
13			Under or over-reactive to clothing	
14			Under or over-reactive to taste	
15			Under or over-reactive to smell	
16			Any unusual fears (please explain)	

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Private Therapy

Therapist's Name:_____

Type of Therapy: (ST, OT, PT, ABA, etc.) _____

_____

_____

CONCERNS: In your own words, please describe your concerns about the child with regard to feeding, speech and language and/or occupational therapy abilities.

_____

_____

_____

_____

_____

What other evaluations have been completed and what were the results, or what were you told?

_____

_____

_____

_____

_____

What treatments have been tried for this problem, and what were the results?

_____

_____

_____

_____

_____

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Please List the Treating Physicians

Current Pediatrician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Other Physicians & Address:

1. _____

2. _____

3. _____

Any other individuals you would like to receive a copy of the Evaluation:

Name & Address:

1. _____

2. _____

3. _____

If you have concerns about the child's feeding development, please fill out the next pages. If not, please go to the last page and sign.

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If the child eats by mouth, please answer the following questions:

6 a. List the foods the client will currently eat and drink (put a star next to their favorites):

_____

_____

_____

6 b. List any foods the client refuses:

_____

_____

_____

Indicate with a check mark any aversions/problems or preferences your child may have:

Food Groups	Likes	Dislikes	Refuses	Difficulty Managing
Thin liquids (e.g., water)				
Thick liquids (e.g., milkshakes)				
Purees (e.g., pudding)				
Textured puree (e.g., applesauce)				
Mixed texture (e.g., cereal with milk)				
Soft solids (e.g., banana, cheese)				
Crunchy solid (e.g., Cheeto, cracker)				
Chewy solid (e.g., meat)				
Cold foods				
Room temperature foods				
Warm foods				

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7. Does the client have food preferences based on color, shape, or flavor (sweet, salty, sour)?
If yes, please explain:

_____

_____

_____

8. Does the client have any other feeding preferences or aversions not mentioned above?
If yes, please explain:

_____

_____

_____

If the child is tube fed, please answer the following questions:

7 a. What type of formula is used and how is it mixed (e.g., pre-blended, blender)?

_____

_____

7 b. Please detail the client's feeding schedule below:

Time of Feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period or what rate?

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7 c. Describe where the client is tube fed and what activities are occurring at the same time:

_____

_____

7 d. Describe the client's reactions to the tube feedings (connecting, during, disconnecting):

_____

_____

8. Is there anything else you feel would help us better prepare for this client's evaluation, please let us know here:

_____

_____

_____

_____

_____

_____

_____ _____

Client / Parent Signature Date

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