JABBERDOGS
SPEECH & OT

415 Huntington Drive #102
San Marino, CA 91108
FAX 626-345-5748
TEL 626-460-0281

MEDICAL HISTORY FORM

Childs's name: _____ Birthdate/age: _____

Parent/caregiver contact information:

Name: _____

Address: _____

Email: _____

Phone: _____

Sibling(s)' name and age: _____

In your own words, what is the child's difficulty, and what do you think may have caused it?

_____

_____

_____

_____

When did you first notice the problem? _____

Pediatrician: _____ Phone: _____

Current Medications: _____

Other doctors (dentist/orthodontists/psychologists) that provide care to this child:

Name Specialty City

_____

_____

_____

Previous evaluations (list): _____

Diagnosis: _____ Made by: _____ When: _____

Has your child previously been treated or evaluated by an OT? When?

_____

_____

Has your child received any other therapy to date (list) How long? By whom?

_____

_____

Are there any legal issues (i.e. custody arrangements) relevant to your child's treatment?

_____

Does your child have any behavioral health concerns that we should be aware of?

_____

Are there cultural or spiritual considerations that may impact your child's treatment?

_____

Do you or your child need interpreter / language assistance services? If so, for what language?

_____

Prenatal/Birth History

Please check all that apply

□ Normal pregnancy and birth □ Full term If not, how many weeks? _____

□ vaginal □ cesarean □ breech □ feet first □ induced labor □ premature □ multiple births

□ NICU □ jaundice □ low APGARS □ complications/illnesses during pregnancy

□ poor health or injury at birth □ problems sucking □ problems breathing at birth

□ oxygen required □ fed via breast, bottle, non-oral □ poor weight gain

□ any concerns that may have affected gestation/birth? (respiratory, circulatory, gastrointestinal)

_____

Medical History

□ seizures □ high fevers □ Autism □ ADHD □ Down Syndrome □ encephalitis
□ pneumonia □ tonsillitis □ concussions/head trauma □ enlarged glands □ chronic colds
□ heart trouble □ asthma □ sensory disorder □ developmental delay □ anxiety
□ constipation □ reflux/vomiting/colic □ recurrent/serious illnesses □ operations/surgeries
□ torticollis □ accidents/physical injuries □ vision problems □ hearing difficulty
□ sinus infections □ mouths objects/fingers/clothing etc.
□ other _____ □ allergies _____

Please list (with the date of occurrence) any surgeries or physical injuries:

_____

_____

_____

Does your child require any adaptive or medical equipment? (e.g. wheelchair, leg/arm brace, supplemental oxygen etc.)

_____

_____

_____

Has your child had ear infections? List frequency and severity. Were antibiotics effective in treating the problem?

_____

_____

_____

Has your child vision or hearing testing? When? Do you have any concerns about testing?

_____

_____

_____

Does your child have prescription glasses to correct vision? _____

Developmental History

Check the behaviors that describe your child as an infant:

□ cried a lot, fussy, irritable □ easy-going □ alert □ liked being held

□ floppy or low tone □ stiff or high tone □ very active □ quiet/calm

□ had colic or reflux □ slept well □ had challenges sleeping

Has your child had any feeding difficulties? Check each item that applies:

□ sucking or nursing □ excessive length of time to drink bottle

□ regurgitation of liquids or solids through the nose

□ food refusal □ gags frequently □ resistant to new foods □ coughs during meals

□ tongue thrust □ constipation □ vomiting □ food allergies

□ diet restrictions/medically ordered □ weight loss □ poor weight gain □ reflux

□ difficulty chewing or swallowing meats □ challenges managing multitextured foods

Does your child choke while eating? Y/N What foods? _____

Is your child a picky eater? Y/N What type of foods does s/he prefer? _____

Does your child drool more than other child his/her age? Y/N

Does your child use a pacifier? Y/N

Does your child use a sippy cup? Y/N

Age when child: (If you can't remember specific times, please indicate if it occurred at the expected time or was delayed).

rolled over: _____ sat up alone: _____ crawled: _____

cruised: _____ walked: _____ made wants known: _____

bottle fed (how long): _____ breast fed (how long): _____

started solid foods: _____ used a straw: _____

used cup without lid: _____ developed a hand dominance: _____

Fine Motor Development

Do you have any concerns related to your child's fine motor control?

_____

_____

Child's hand preference/dominance: Right/Left/None

Does your child have challenges in any of the following areas **(mark all that apply)?**

□ coloring/drawing/handwriting □ cutting, gluing or folding paper □ manipulating small items

□ using two hands in play or a functional task □ opening or closing containers

□ catching a ball □ overall hand strength □ copying letters/shapes/designs from a model

□ playing with constructive toys such as Legos

Sensory/Gross Motor Development

Do you have any concerns related to your child's gross motor control or sensory development?

_____

_____

Please check all that apply:

□ my child can be described as high energy

□ my child likes "rough and tumble" play and tends to run into objects/crash/fall frequently

□ my child tends to lean on walls/tables/people

□ my child has poor postural control or weak core strength (e.g. my child has trouble maintaining an upright posture when sitting)

□ my child tends to avoid unfamiliar tasks or tasks they perceive as challenging

□ my child has a low frustration tolerance

□ my child enjoys movement/swinging/spinning

□ my child avoids movement/swinging/spinning

□ my child is uncoordinated or has poor balance

□ my child seems to have a high pain tolerance

□ my child seems very aware of sounds/noises in the environment

□ my child frequently misses / is unaware of sounds and noises in the environment

□ my child seems very aware of movement or visual information in the environment

□ my child frequently misses / is unaware of movement or visual information in the environment

□ my child has a strong aversion to certain strong smells

□ my child seeks out certain smells

□ my child is sensitive to light or unexpected touch

□ my child avoids certain textures (e.g. glues, sand, playdough, tags/seams on clothes)

□ my child seeks out tactile play and likes to touch everything

Self Help Skills

Do you have any concerns related to your child's self-help skills?

_____

_____

_____

Does your child have challenges in any of the following areas **(mark all that apply)?**

□ managing fasteners (zippers, buttons, snaps, clasps) □ tying their shoes □ using a spoon

□ using a fork □ using a fork and knife to cut food or use a knife to spread butter

□ drinking from an open cup □ putting on or taking off a jacket/shirt

□ putting on or taking off pants □ putting on or taking off shoes and socks

□ taking a bath or shower □ washing hands □ opening containers

□ opening doors using a knob or handle □ buckling their seatbelt

□ following self-care routines (e.g. getting ready in the morning or a bedtime routine)

□ brushing teeth □ brushing hair / hair management (haircuts) □ cutting/filing nails

Home and Community

Do you have any concerns related to your child's ability to access their home/school or community safely?

What aspects of the day are the most challenging for your child? Why? (e.g. meal times, bed/bath time, etc.)

When your child is upset or overwhelmed, what calms them down?

How does your child transition between new and familiar people and or places?

What activities does your child enjoy?

What are your child's fears?

School History

Educational Setting	Location/School	Teacher	Special Services
Infants and Toddlers			
Childcare Facility			
Preschool			
Elementary School			
Middle School			
High School			

How would you describe your child's relationship with his teacher and peers?

_____

_____

_____

Do you have any concerns about your child's social-emotional skills?

_____

_____

_____

What are your child's areas of academic difficulty?

_____

_____

_____

Is there any additional information you would like me to know about your child?

_____

_____

_____

_____

_____

Completed by (Please sign) _____ Date _____

**** Please return this form along with copies of previous evaluations, educational plans or other reports you would like us to consider when assessing your child. ****