A STEP AHEAD PEDIATRIC THERAPY, Inc.

BACKGROUND INFORMATION QUESTIONAIRE

Child's Name: _____ **Birth date :** _____

Address: _____ **Home phone:** _____

_____ **Language spoken at home:** _____

Child's Primary Physician:

_____ _____ _____
Name Address Phone

Emergency Contact and Phone while at A Step Ahead, Pediatric Therapy: _____

Mother's Name: _____ Place of employment: _____ Work Phone: _____

Father's Name: _____ Place of employment: _____ Work Phone: _____

Whom does child live with: _____ Number of Siblings _____

What type of treatment is your child seeking ? _____ OT _____ PT _____ ST

COUNTY SERVICES/PUBLIC SCHOOL SERVICES

Check below the services the child is receiving or has received in the past

____Evaluated by 1st Steps Date of evaluation: _____

____Attends or attended Head Start or Preschool Date of attendance: _____

____Evaluated by child's public school What _____ Date of evaluation: _____

SERVICES FROM OTHER SOURCES

Evaluated or received therapy for the following:

____Occupational Therapy ____Physical Therapy ____Speech/Language Therapy ____Psychologist

PREGNANCY AND BIRTH HISTORY

PREGNANCY was: ____Full Term ____Premature ____Past Term

Prenatal care: _____Yes _____No Length of time _____

How much weight did mother gain during pregnancy? _____lbs.
Hours of labor (from the first contraction to birth): _____hrs.
Complications during pregnancy: _____

Did the mother experience any of these during pregnancy?

	No	Yes		No	Yes		No	Yes
Anemia	__	__	German Measles	__	__	RH Incompatibility	__	__
High blood pressure	__	__	Virus	__	__	Operation	__	__
Toxemia	__	__	Chronic Illness	__	__	Hospitalization	__	__
Kidney Disease	__	__	Gestational Diabetes	__	__	Threat of Miscarriage	__	__
Heart Disease	__	__	Thyroid	__	__	Medications	__	__
Bleeding	__	__	Kidney Disorders	__	__	Injury	__	__

BIRTH	NO	YES		NO	YES
Natural Childbirth	€	€	Was cord around baby's neck?	€	€
Any anesthesia	€	€	Was baby's color normal?	€	€
Labor induced?	€	€	Did baby cry quickly?	€	€
Breech (feet first)?	€	€	Did baby receive oxygen?	€	€
Forceps used?	€	€	Did baby have light therapy?	€	€
Caesarian?	€	€	Did baby receive blood?	€	€
Complications	€	€	Did baby go on a respirator?	€	€

Birth weight: ____lb. ____oz. **Apgar Score: ____ at 1min. ____ at 5 min.**

CHILD'S DEVELOPMENTAL HISTORY

INFANCY

Please note any difficulties during infancy (before 1 year old).

	No	Yes		No	Yes		No	Yes
Feeding	€	€	Weak cry	€	€	Reflux	€	€
Sleeping	€	€	Limp when picked up	€	€	Abnormal activity	€	€
Colicky	€	€	Stiff/Rigid	€	€	Convulsions	€	€
Low weight gain	€	€	Tremors	€	€	Abnormal Growth	€	€

What was baby's temperament? €Easy €Demanding €Cried a lot €Passive

Please note any other difficulties: _____

DEVELOPMENT

At what age did your child accomplish the following, independently?

	Months	Years	Starting to	Not yet
Sat alone	_____	_____	_____	_____
Crawled	_____	_____	_____	_____
Walked without holding on	_____	_____	_____	_____
Talked using single words	_____	_____	_____	_____
Talked using sentences	_____	_____	_____	_____
Fed self	_____	_____	_____	_____
Followed simple directions	_____	_____	_____	_____
Drank from a glass	_____	_____	_____	_____
Chewed adult type food	_____	_____	_____	_____
Go up/down stairs	_____	_____	_____	_____
Toilet trained – bladder	_____	_____	_____	_____
Toilet trained – bowel	_____	_____	_____	_____
No toileting accidents	_____	_____	_____	_____
Dressed self	_____	_____	_____	_____
Wrote letters	_____	_____	_____	_____
Tied shoes	_____	_____	_____	_____
Pedaled tricycle	_____	_____	_____	_____
Rode bicycle	_____	_____	_____	_____

DO YOU HAVE OR USE ANY OF THE FOLLOWING ADAPTIVE EQUIPMENT?

	No	Yes
Mobility Aids (wheelchair, walker, etc.)	€	€
Feeding Aids (special spoon or cup, etc,)	€	€
Bathing Aids (bath chair, etc.)	€	€
Adapted Toys (switches, etc.)	€	€
Adapted Play Equipment (picture board, electronic communication device, etc.)	€	€

List other equipment: _____

CHILD'S BEHAVIOR

Please check all the characteristics you feel describe your child.

€ Outgoing	€ Often sad	€ More active than most	€ Sleeps through the night
€ Happy	€ Impulsive	€ Clumsy with hands	€ Puts own self to sleep
€ Immature	€ Temper tantrums	€ Clumsy when walking	€ Nail biting
€ Loving	€ Shy	€ Short attention span	€ Stubborn
€ Well behaved	€ Thumb sucking	€ Difficulty paying attention	
€ Argumentative	€ Head banging	€ Falls frequently	

CHILD'S MEDICAL HISTORY

General health: €Excellent €Good €Fair €Poor
Explain if fair poor: _____

My child has been diagnosed with the following chronic (long term) conditions:
_____

			Explain
Allergies?	€No	€ Yes	_____
Taking any medication?	€No	€ Yes	_____
Ear Infections?	€No	€ Yes	_____
Hearing	€Seems okay	€ Has been tested	_____
Vision	€Seems okay	€ Has been tested	_____
Current eating habits	€Good	€Fair	€Picky

List any Surgeries _____

Serious Injuries explain: _____

Other Physicians (Neurologist, Physical Medicine, Psychiatrist, Surgeon etc.) involved with child:
1) _____
Name & Specialty Address Phone

2) _____
Name & Specialty Address Phone

NOTE: PLEASE BRING or SEND ANY CURRENT REPORTS (less than three years old)

_____
Signature of person completing this form

_____
Relationship to the child