JABBERDOGS
SPEECH & OT

415 Huntington Drive Suite 102
San Marino, CA 91108
FAX 626-345-5748
TEL 626-460-0281
Carley@jabberdogs.com

MEDICAL HISTORY FORM

Childs's name/birthdate/age:

Parent/caregiver contact information:

Name:

Address:

Email:

Phone:

Sibling(s)' name and age:

Please state in your own words what you think the child's problem is.

_____

_____

_____

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?

_____

Prenatal/Birth History

Please check all that apply

□ normal pregnancy and birth □ full term If no, 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 □ 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 or dietary restrictions_____**

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/did your child use a pacifier? Y/N

Does /did 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: _____

make wants known: _____ bottle feed (how long): _____ breast feed (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 such as zippers, buttons, snaps, and 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/Grade Level	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. ****