PATIENT HISTORY INFORMATION

Thank you for taking the time to fill out this form as completely and honestly as possible. Your input plays an important role in the evaluation process. All the information on this form is confidential and will not be released without your permission.

IDENTIFYING INFORMATION

Person Completing Form: ______________________________ Relationship to Child: ______________________

Child's Name: ____ Date of Birth: _____________ ☐ M ☐ F

What do you hope to gain from this evaluation?

FAMILY BACKGROUND

Mother's Name: ____________________ Age: ________ Father's Name: ______________________ Age: ________

Occupation: ____________________________________ Occupation: ______________________________________

Is this child: ☐ Your Biological Child ☐ Step Child ☐ Adopted Child ☐ Foster Child

If not your biological child, at what age did he/she come into your home:

Persons living in the home:

Language spoken in the home:

Does anyone related to this child have speech, language, learning or physical development problems? ☐ Yes ☐ No

If yes, please describe:

BIRTH HISTORY

☐ *BIRTH HISTORY UNKNOWN*

Length of pregnancy with this child: ________ weeks

Measurements of the child: Weight: ________ Length: ________

Apgar Scores (if known): 1 minute: ________ 5 minutes: ________ 10 Minutes: _______

Did mother experience any of the following during pregnancy?

- ☐ Excessive Illness
- ☐ Emotional Upsets
- ☐ Exposure to drugs/alcohol
- ☐ Flu
- ☐ Injury
- ☐ Marked Swelling of Hands/Feet
- ☐ Bleeding/Spotting
- ☐ Rh Incompatibility

How would you describe the labor? (check all that apply)

- ☐ Easy labor, spontaneous onset
- ☐ Normal birth experience
- ☐ Forceps/suction used
- ☐ Hard labor
- ☐ Breech presentation
- ☐ C-section delivery
- ☐ Induced labor

Condition of infant immediately after birth (check all that apply)

- ☐ Normal, no problems
- ☐ Difficulty with feeding, sucking, swallowing
- ☐ Breathing problems
- ☐ Jaundiced
- ☐ Birth Injury
- ☐ Congenital differences

Did any of the following occur during infancy? ☐ Does Not Apply

- ☐ Excessive crying
- ☐ Difficulty feeding/sucking/swallowing
- ☐ Injury
- ☐ Breathing problems/ respiratory illness
- ☐ Other:

Please explain:

Health / Medical History

Developmental Diagnosis (e.g. autism, global developmental delay, etc.)	Medical Diagnoses:
Is your child is good health? ☐ Yes ☐ No Is the child taking any medications? ☐ Yes ☐ No If yes, please list medication(s), dosage, and why used: (Example: Depakote for seizures)	☐ **No Know Medication or food allergies** Please list any food or medication allergies:

Has the child seen the following specialists? (check all that apply)

☐ Ear/Nose/Throat Specialist ☐ Orthopedic Surgeon ☐ Other ______
☐ Neurologist ☐ Psychologist
☐ Ophthalmologist and/or Vision Therapist ☐ Psychiatrist

Please include names and phone numbers of specialist(s):

Explain reason child is seeing specialist(s):

Has the child ever had an operation or been hospitalized? ☐ Yes ☐ No

Dates/Surgery/Hospital: ______
Dates/Surgery/Hospital:

Hearing	Vision
Do you have concerns regarding your child's hearing? ❒ Yes ❒ No	Has your child's vision been tested? ❒ Yes ❒ No
Does your child have a history of frequent ear infections? ❒ Yes ❒ No	When: ______
If yes, number of ear infections per year: ______	Where: ______
Has your child's hearing been tested? ❒ Yes ❒ No	Results: ______
When: ______	Does your child wear glasses? ❒ Yes ❒ No
Where: ______	
Results: ______	
Does your child wear hearing aids, use an FM system or have a cochlear implant? ❒ Yes ❒ No If yes, what kind?	

Does your child have seizures? ❒ Yes ❒ No
If yes, please specify type and frequency:

FEEDING/SWALLOWING	SLEEPING
Does your child exhibit problems with feeding/swallowing? ❒ Yes ❒ No If yes, please specify: ❒ Dysphagia ❒ Selective ('picky') eater ❒ Drooling ❒ Other (please specify): ________________________________	Does your child experience difficulty sleeping? ❒ Yes ❒ No If yes, please describe:

EMOTIONAL / SOCIAL DEVELOPMENT

How would you describe your child's personality?

Does your child play and engage socially with other children his/her age? ☐ Yes ☐ No

What are your child's favorite activities?

Describe any concerns regarding the behavior of your child:

ACADEMIC / THERAPY HISTORY

Does your child attend school? ☐ Yes ☐ Homeschool ☐ No Grade Level: ____________

If yes, name the school: ____________________ School district: ____________

Phone number: ____________________ Name of teacher: ____________

Type of classes attended: ____________________ When did child begin school: ____________

Student/Teacher Ratio: ____________________

Does your child receive the following services? (check all that apply)

Type of Therapy	School Therapist Name, Duration	Private Agency Name, Therapist Name, Duration
Example	*Mary Smith, 2x/week for 30 minutes*	*Anywhere Rehab, John Doe 1x/week for 60 minutes*
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Special Education		
ABA Services		
Other		

ACADEMIC / THERAPY HISTORY (CONTINUED)

List other therapists / specialists your child has seen:

Name / Address	Testing / Treatment Given	Dates of Service

Note: IF your child has had a previous evaluation/re-evaluation (within the last 12 months with another private clinic) your insurance may not cover your scheduled evaluation with MOSAIC (your child's school IEP is excluded). Please call our office if you have your child's latest evaluation and chart notes as your child may begin on-going services with our facility if the reports contain the appropriate information.

Evaluation / Therapy History

Previous Evaluation:	☐ Yes ☐ No		Where:
School IEP:	☐ Yes ☐ No		When:
Was an evaluation done?		☐ Yes ☐ No	When:
Did a licensed therapist do the evaluation?		☐ Yes ☐ No	
Was a re-evaluation done or scheduled?		☐ Yes ☐ No	When?