General Information

Child's Name: _____ _____
(first) (last) (nickname)
Birth Date:_____
Address:_____
City:_____State:_____Zip Code:_____

Best email address to contact parent/caregiver:_____

Parent Name:_____Phone: _____
Parent Name:_____Phone: _____

Primary Physician: _____Phone: _____ _____
Referring Physician:_____ Phone:_____

Child lives with: (check) birth parent (s)_☐_ foster parents_☐_ adoptive parent (s)_☐__

Child's Diagnosis: _____
Please list all medications and vitamins/supplements: _____
_____
Please list all allergies: _____
_____
Does the child have a history of seizures? □ Yes □ No
Has your child ever had a swallowing study or a history of aspiration? □ Yes □ No
If yes, what were the results? _____
_____

Caregiver Concerns

1. Why has your child been referred to TOTS? Please discuss any concerns/problems:

_____
_____

2. What are your goals for your child's current episode of care/therapy program? (Please be as specific as possible and consider what would success look like to you.)

_____
_____

Educational Information

1. Does your child currently attend school/daycare: □ Yes □ No
   Name of School/Daycare: _____Grade Level: _____

2. Does your child have an **IFSP from BCW, IEP, or 504 plan**? □ Yes (circle one) □ No
   If you answered yes, please provide a copy for our records. If your child has any form of Medicaid we must have this in order to get authorization for treatment.

3. Does your child receive any special help or therapy at school? (check all that apply) □ Yes □ No
   □ PT
   □ OT
   □ ST
   □ Vision services
   □ Pull out/Resource services
   □ Classroom or testing accommodations
   □ Behavior Plan
   □ Smaller Class
   □ Self-contained classroom
   □ Other:_____

Additional Medical Providers

1. Has your child ever been seen by any of the following specialists (check all that apply and list the provider, specialty, and date of last visit)

   □ Neurologist _____
   □ Oncologist _____
   □ Cardiologist _____
   □ Pulmonologist _____
   □ ENT _____
   □ Allergist _____
   □ Orthotist _____
   □ Orthopedist _____
   □ Gastroenterologist _____

2. Does your child have a history of any mental health issues? □ Yes □ No
   If yes, please specify: _____

4. Mental Health Provider(s): (check all that apply and list the provider, specialty, and date of last visit)

   □ Psychologist _____
   □ Psychiatrist _____
   □ Counselor _____

5. Is your child receiving any private or other therapy services (OT, PT, ST, etc)? □ Yes □ No
   If yes, please specfy:_____

Family Information & Social Participation:

1. What languages are spoken at home? □ English □ Spanish □ Other _____
2. What language does your child understand and/or speak the best?_____
3. Do you have concerns about your child's ability to play alone or with others? □ Yes □ No
   Additional information: _____
4. Does your child's behavior limit the ability to go to places or participate in activities in the community, including the grocery store, restaurants, etc? □ Yes □ No
   Additional information:_____
5. Does your child tantrum or melt-down often? □ Yes □ No
   If yes, what best helps your child to calm? _____
6. Is your child frustrated easily? □ Yes □ No
7. Does your child have a history of hurting herself/himself or others? □ Yes □ No

Birth and developmental history:

Before Birth:

1. Were any drugs or medication taken during pregnancy? □ Yes □ No
   If yes, please specify:_____

Delivery/ Birth:

1. Was the pregnancy full term? □ Yes □ No
   Specify gestational age and weight at delivery: _____
2. Complications with delivery? □ Yes (check all that apply) □ No
   - □ Jaundice
   - □ Congenital defects
   - □ Scars or bruises
   - □ Required oxygen
   - □ Blood Transfusions
   - □ Tube feedings
   - □ Other:_____
3. How long was your child in the hospital after birth: _____
4. Were there any feeding difficulties after birth? □ Yes □ No
   If yes, please specify and at what age: _____
5. Was your child bottle fed? □ Yes □ No
6. Was your child breast fed? □ Yes □ No
7. Did your child have problems sucking/latching on? □ Yes □ No
8. Did your physician suggest follow-up with any specialists? □ Yes □ No
   If yes, please specify: _____

Medical History:

1. Is your child up-to-date with immunizations? □ Yes □ No
2. Has your child had any of the following (please check all that apply):
   - □ Meningitis
   - □ Diabetes
   - □ Lung issues
   - □ Bronchitis

□ Pneumonia
□ Heart trouble
□ Seizures
□ Allergies
□ Physical Injuries
□ Asthma
□ Chronic Ear Infections
□ Ear tubes
□ Cancer
□ Headaches
□ Reflux
Additional information: _____

3. Has your child ever been hospitalized? □ Yes □ No
   If yes, please specify why: _____
4. Has your child had any surgeries? □ Yes □ No
   If yes, please specify: _____
5. Is there a family history of seizures? □ Yes □ No

Vision & Hearing

1. Has your child had a vision evaluation? □ Yes □ No
   If yes, by whom & date of evaluation: _____
2. Does your child wear glasses or contacts? □ Yes □ No
3. Has your child had a hearing evaluation by an audiologist? □ Yes □ No
   Date & Results: _____

Developmental History:

1. Is there a family history of speech, motor or cognitive delays? □ Yes □ No
2. Overall, how would you describe your child's development as compared to other children of the same age?
   □ Faster
   □ Slower
   □ Same as
3. How would you describe your child's tolerance for pain as compared to other children of the same age?
   □ Greater than
   □ Less than
   □ Same as

Motor Development:

1. At what age did your child:
   Roll over ?_____Sit alone?_____
   Crawl?_____Pull to stand? _____
   Walk independently? _____

Speech & Language:

1. At what age did your child:
   Babble?_____
   Say first words?_____
   Use 2-word combinations?_____
   Use short sentences? _____
2. Does your child understand what you say to him/her? □ Yes □ No

3. How does your child currently communicate (check all that apply)?
   □ Gestures/Pointing
   □ Waving
   □ Single words
   □ Phrases
   □ Sentences
   □ Pictures
   □AAC Device
   □ASL/Sign Language

4. Does your child have difficulty with producing specific sounds? □ Yes □ No
   If yes, please specify: _____

Sensory-Motor Development:

1. My child seems to be very sensitive to:
   □ Sounds
   □ Touch
   □ Vision
   □ Movement
   □ Taste
   □ Smell
   □ Does not apply

2. My child doesn't seem to notice:
   □ Sounds
   □ Touch
   □ Vision
   □ Movement
   □ Taste
   □ Smell
   □ Does not apply

3. My child often has trouble learning new movements. □ Yes □ No
4. Does your child tend to be clumsy and have balance/coordination problems? □ Yes □ No
5. Does your child appear to enjoy falling or crashing into things? □ Yes □ No
6. My child prefers:
   □ Bright light
   □ Dark
   □ No preference

7. My child prefers:
   □ Strong smells
   □ Avoids smells
   □ No preference
8. Does your child startle easily? □ Yes □ No
9. Did your child soothe to swaddling as an infant? □ Yes □ No

Fine Motor Development

1. Does your child have a hand dominance? □ Right □ Left □ Ambidextrous
2. Does your child switch hands during tasks? □ Yes □ No □ Sometimes

Activities of Daily Living (ADL)

Ease of Performance: Can your child….	Yes	No	Some Difficulty
Finger feed self?			
Feed self with spoon?			
Feed self with fork?			
Cut food with knife?			
Drink from a straw?			
Drink from a cup with no lid?			
Help push arms/ legs into clothing for dressing?			
Take off shoes/socks?			
Put on shoes/socks?			
Take off pants/ shorts?			
Put on pants/shorts?			
Take off shirt?			
Put on shirt?			
Unbutton/button large buttons?			
Zip/ unzip a jacket?			
Brush teeth?			
Brush hair?			
Shower/ bathe self?			
Potty trained?			

Feeding/Swallowing:

1. Do you have concerns regarding how your child eats or swallows? □ Yes □ No
2. Does your child eat a variety of foods? □ Yes □ No

If your child was referred for feeding therapy or you have feeding concerns, please continue to the next page and complete the following feeding questions.

**** If you are here for feeding therapy, please fill out the following page.*

1. What is your major feeding concern? Please describe feeding problem.

   _____

   _____

2. What is your feeding goal for your child? _____

   _____

3. History of GI surgery □ Yes □ No
   If yes, please explain: _____

   _____

4. Did your child ever receive any alternative feedings? □ Yes □ No
   If yes, please select (all that apply):
   □ NG- tube
   □ G-tube
   □ J-tube
   □ TPN
   □ Other: _____

   Type of feeding received (please check): □ Bolus □ Continuous □ Combination □ Other
   Please describe feeding schedule/routine: _____

   _____

5. ENT: (Please check any that apply)
   □ Ear infections
   □ Pneumonia
   □ Aspiration
   □ Coughing/choking episodes when eating
   □ Bronchitis
   □ Upper Respiratory Infections

6. Feeding history
   Were there any feeding difficulties after birth? □ Yes □ No
   If yes, please specify:
   Breast fed: □ Yes □ No If yes, at what age did he/she wean _____
   Bottle fed: □ Yes □ No Breast milk or Formula Current formula: _____
   Did your child have any difficulties sucking/latching on? □ Yes □ No
   Solids: at what age were cereals/baby foods introduced? _____
   Select the stages of baby food that your child ate/eats: □ 1st □ 2nd □ 3rd □ Toddler/diced
   Any problems? _____

7. Dysphagia: Does your child have problems with swallowing/coughing/choking: □ Yes □ No
   Age started: _____ Please describe: _____
   Hx of: Aspiration □ Yes □ No Penetration: □ Yes □ No
   Has your child received a Barium swallow study: □ Yes □ No Date of study: _____

Does your child have any feeding precautions? □ Yes □ No
Please explain: _____
Did your physician suggest follow up with any specialists? □ Yes □ No
If yes, please specify: _____

8. Does your child eat a variety of foods? □ Yes □ No

9. Food list
   List of preferred foods:

   List of non-preferred foods:

10. Current Meal Pattern
    Please indicate your child's typical meal schedule. Number/timing of meals/snacks: _____

    _____

    _____

11. What does your child sit in during meals (highchair, dining room chair, etc.): _____

12. How long does it usually take for your child to eat a meal? _____

13. What feeding techniques do you use with your child to get him/her to eat? _____

    _____

14. What does your child drink from (check all that apply): □ Bottle □ Sippy Cup □ Open Cup □ Straw

15. Is your child able to self-feed? □ Yes □ No

16. Does your child currently use a feeding utensil (spoon/fork): □ Yes □ No