Sensory Link, LLC
Pediatric Therapy

2400 Wildwood Rd.
Gibsonia, PA 15044

Today's Date: ______________________________

DEVELOPMENTAL / MEDICAL HISTORY FORM

DEMOGRAPHIC INFORMATION

Child's name:	**Date of Birth:**
Sex: ☐ **Male** ☐ **Female**	**Diagnosis:**
Dietary Restrictions:	**Allergies/Precautions:**
Parent/Guardian Name(s):	**Presenting problems/Concerns:**
Address: Street: ______________________ ______________________ City: ______________________ State: __________ Zip code: __________	**Contact information:** Home phone: ______________________ Work phone: ______________________ Cell phone: ______________________ Email: ______________________

MEDICAL INFORMATION:

PCP's Name: **Phone#:**	**Referred by:**
PCP Address: Street: ______________________ ______________________ City: ______________________ State: __________ Zip code: __________	**Reason for referral:**
Primary Insurance Information:	**Secondary Insurance Information:**
Bill Address: Street: ______________________ ______________________ City: ______________________ State: __________ Zip code: __________	**Bill Address:** Street: ______________________ ______________________ City: ______________________ State: __________ Zip code: __________
Insured's name:	**Insured's name:**
DOB:__________ ID# ______________________ Group # ______________________	DOB:__________ ID# ______________________ Group #______________________

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PAYOR ID # ______________ ☐HMO ☐ PPO	PAYOR ID # ______________ ☐HMO ☐ PPO
Deductible amount ______________ Amount met ______________ Policy Type ______________ Co-pay Amount ______________	Deductible amount ______________ Amount met ______________ Policy Type ______________ Co-pay Amount ______________
Max visits ________ Visits met________ Policy Period ______________ Authorization needed ☐Yes ☐No	Max visits ________ Visits met________ Policy Period ______________ Authorization needed ☐Yes ☐No
Assistive Devices? Please check ☐ Glasses ☐ Hearing aid ☐ Walker ☐Wheelchair ☐AFO's ☐Splint	☐Communication book ☐ AAC device ☐Mode of Communication ______________ ☐Other

BIRTH HISTORY

Please circle Full-term/ Premature	Number of weeks:	Birth Weight:
Complications? (Please explain)		
Did the infant require any hospitalizations? (Please explain)		
Was there a need for oxygen, transfusions, or tube feedings? (Please explain)		

MEDICAL HISTORY

	Yes	No	Date and Results
Vision Evaluated			
Hearing Evaluated			

HEALTH CONDITIONS (Please check any that this child has now or has had in the past and comment)

	Birth or congenital malformation		Heart Disease
	Seizures		High Fevers
	Vision problems		Diabetes
	Multiple ear infections (3 or more)		Measles
	Tonsils/Adenoid problems		Chicken Pox

	Upper respiratory infections		Eczema
	Behavior Problems		Asthma
	Emotional Problems		Sleeping problems
	Nervous Tics or Tourettes		Chronic diarrhea
	Meningitis		Constipation
	Cancer		Urinary Tract Infections
	Cystic Fibrosis		Wetting during the day
	Abnormal spinal curvature		Bedwetting at night
	Arthritis		Other

Is your child presently receiving any medications?

Medication	Dosage/Frequency	Purpose of Medication

DEVELOPMENTAL HISTORY

Please describe any concerns you noted in your child's development. ____________________________

____

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DEVELOPMENTAL HISTORY (CONTINUED)

When did your child achieve the following? COMMENTS

Roll over	
Sit unsupported	
Crawl	
Walk	
Eat solid foods	
Drink from a cup	

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Use a spoon independently	
Put on shirt independently	
Become completely toilet trained	
Began babbling	
Say 1st words	List:
Combine 2 words	
Speak in sentences	Longest 2 sentences this week: ____________ ____________
Was the crawling phase brief?	☐ Yes ☐ No
Did the child use a walker?	☐ Yes ☐ No If yes, how often?

EDUCATIONAL HISTORY

Please circle PUBLIC / PRIVATE SCHOOL	NAME OF SCHOOL:	GRADE:
CLASSROOM TYPE:		
Does your child receive any services through school? (please list the amount of services in each area)	OT	PT
	SLT	Resource

CHALLENGES / CONCERNS and Comments

Self-care abilities	
Feeding	
Communication/Language	
Social Skills	
Play	
Behavior	
Motor Skills	

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Sensory Concerns	
Other	

HELP US GET TO KNOW YOUR CHILD

How does your child typically spend their time?	Describe the environment they spend the majority of their time.
List extra-curricular activities:	Responsibilities/Roles/Chores at home:
Family routines, traditions and cultural activities:	What may cause tantrums, outbursts, etc?
Child's likes/preferences (food, toys, shows, movies, etc.)	Child's dislikes (things that will upset or to avoid):
What do you view as your child's strengths?	What areas do you see as challenging?

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Are there any other medical precautions, behaviors, or precautions that the evaluating therapist should be aware of? ____

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Have any other recent evaluations been completed prior to this assessment? ☐ Yes ☐ No
Please list the profession and the dates of services below (Please include copies of these reports)

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What information would you like to gain from this evaluation? What are your primary concerns / goals? ____

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Who may we thank for this referral? ____