MEDICAL AND DEVELOPMENTAL HISTORY

Dear Parents,

Please complete the following medical and developmental history in order to help us more fully understand and benefit your child in a program of perceptual motor therapy. Where applicable., both parents should cooperate in reporting the requested information.

Child's full name _____ Nickname _____

Address _____

_____

Phone _____ (mom's home) _____ (dad's home)

_____ (mom's cell) _____ (dad's cell)

E-mail _____

Current date _____ Child's DOB _____ Child's age _____yrs._____mos.

Grade _____ Name of School _____

Father's name _____ Age _____

Father's occupation _____ Education _____

Mother's name _____ Age _____

Mother's occupation _____ Education _____

Siblings' names and ages _____

_____

Please indicate the primary reason for referral to perceptual motor therapy _____

_____

Referred to program by _____

Pediatrician _____ Phone _____

BIRTH HISTORY

1. Was this a full term pregnancy? Yes / No If no, length of time _____

2. Was this a normal pregnancy in every respect? Yes / No If no, please explain _____

_____

3. Apgar rating, if known 1 minute _____ 5 minutes _____

4. Was this a normal birth in every respect? Yes / No If no, please explain _____

_____

5. Child's weight at birth _____ Length _____

HEALTH HISTORY

Please answer yes or no to the following questions. Where an explanation is necessary, please use the back of the paper and place an asterisk next to those questions to which you have provided an explanation. Please be sure to preface each explanation with the proper question number.

Has your child ever

Y N 1. had a speech defect or problem with letters or sounds?

Y N 2. had a hearing problem or history of frequent ear infections?

Y N 3. had an orthopedic problem?

Y N 4. worn braces or bars?

Y N 5. worn corrective shoes?

Y N 6. been in a cast for any reason?

Y N 7. had problems with limbs (arms, legs, hands, feet)?

Y N 8. been forced to spend long periods convalescing from illness?

Y N 9. had convulsions?

Y N 10. had a very high fever?

Y N 11. been unconscious?

Y N 12. been hospitalized?

Y N 13. suffered a serious fall?

Does your child

Y N 14. have any allergies?

Y N 15. have difficulties in sleeping or have any unusual sleep habits?

Y N 16. have a known visual problem?

Y N 17. complain of any of the following: double vision, itching around the eyes, burning eyes, blurred vision, eye fatigue *(please circle*) ?

Y N 18. appear to have poor coordination?

Y N 19. get along well with other children of the same age?

Y N 20. appear clumsy or awkward in games?

Y N 21. compare favorably with children of the same age in general coordination?

Y N 22. appear careless with personal belongings?

Y N 23. Was child an active baby?

Y N 24. Is child active now?

Y N 25. When fatigued, does child sag, become irritable, or excited? (*please circle*)

Y N 26. Is child currently under the care of a physician?

Y N 27. Is child currently taking any medication? If yes, please list _____

_____

28. Please list all illnesses (other than minor colds) and their approximate dates _____

_____

DEVELOPMENTAL EVENTS

To the best of your ability, indicate at what age each of the following events occurred:

1. Rolled over _____
2. Sat up without support _____
3. Fed self _____
4. Crawled _____
5. Stood holding onto furniture _____
6. Walked unassisted _____
7. Threw ball _____
8. Put shoes on (not tied) _____
9. Pealed tricycle _____
10. Buttoned clothes _____
11. Tied shoes _____

SCHOOL PROGRESS

1. Did (does) child attend a preschool program? Yes / No If yes, at what age and for how long? _____

_____

2. Age at entrance to kindergarten _____yr.s_____months

3. Does child like school? Yes / No If no, please explain _____

_____

4. Has child ever repeated a grade? Yes / No If yes, please explain _____

_____

5. Any school difficulties? Yes / No If yes, please explain _____

_____

6. What is child's weakest subject in school? _____

_____

FAMILY RELATIONSHIPS

1. Has there been a separation between parents and child during the child's lifetime? Yes / No If yes, please explain _____

2. Is there a good relationship between parents and child? Yes / No If no, please explain _____

_____

_____

3. Is there a good relationship between siblings? Yes / No If no, please explain _____

_____

_____

4. Does any member of the family have problems similar to that of the child? Yes / No If yes, please explain _____

_____

CHILD'S PERSONALITY

1. Is child a happy person? Yes / No If no, please explain _____

_____

2. Does child have any fears? Yes / No If no please explain _____

_____

ADDITIONAL COMMENTS: _____

_____

_____

_____

_____

_____

_____

Thank you very much for your time. We look forward to working with you and your child.