



## Personal Information

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Please list any adults and children that live in your home and the relationship to your child:  
(Please include nicknames.)

Who are friends, teachers etc. your child may enjoy talking about?

*The most important thing I want you to know about this child is...*

*What are your main concerns or questions we can address during your child's evaluation?*

## Medical History

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Please describe pregnancy and delivery of your child:

Has your child ever lost consciousness or sustained a significant head trauma?

Has your child's **hearing** been screened within the last year? If yes, what were the results?

Does your child experience **middle ear infections**? If yes, when was the last known infection?

Do you have concerns regarding your child's **vision**? If yes, has he/she received a vision evaluation, when, and with whom?

**Hospitalizations and/or surgeries:** Please list dates and reason (if applicable):

Please describe any additional medical concerns:

**Current Health** \_\_\_\_\_

Current **Diagnoses** and **ICD-9 codes** (if known):

Current **Medications**:

Allergies to medications or foods?

Describe any **sensory** seeking behaviors or sensitivities (noise, taste, sound, touch):

Are there any **nutritional or feeding** concerns?

Most recent height: \_\_\_\_\_ weight: \_\_\_\_\_

**Primary Care Physician:**

Name:

Address:

Phone:

Fax:

Does your child see any other **specialists**?

## School Information

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Name of School:

Grade:

Address:

Phone:

Name of Teacher:

Any **Special Education** services?    Y    N    Please list name of providers if known.

Speech:

OT:

PT:

Other:

Next IEP/IFSP meeting?

## Therapy Services

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Has your child received prior **Speech or Occupational Therapy** services?    Y    N

Name of practice:

Dates Attended:

Address:

Phone:

Fax:

Description of goals/progress:

Does your child receive **Physical Therapy** services anywhere?

Has your child received a Speech or Occupational Therapy **evaluation** in that past 12 months?

Y    N    *Please attach report(s).*

## Equipment List (if applicable)

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Please use attached questionnaire to list any equipment that your child uses or that you are interested in.

***Thank you for taking the time to complete this questionnaire, it will be helpful in assessing your child's needs and planning appropriate therapy intervention!***

## Assistive Technology Equipment Questionnaire

Does your child have any of the following equipment? Please *check boxes & circle items* that apply. Please place a \* next to any item that you are interesting in learning more about.

**Augmentative Communication:**

Communication book    Step-by-Step    Big Mac    Hi-tech device  
Switches                      Mount                      Other

**Computer access:**

Switches    Switch port    Adaptive mouse    Adaptive keyboard    Software    Other

**Environmental control units (ECU):**

Powerlink                      Access to home electronics                      Other

**ADLs:**

Bath chair                      Shower chair                      Adaptive toilet seat/bedside commode

**Hearing and listening aids**

**Vision and reading:**    Low vision products                      Glasses  
(Near-sighted                      Far-sighted                      Strabismus                      Other)

**Mobility:**

Manuel wheelchair                      Powered wheelchair                      Walker                      Gait trainer

**Seating and positioning:**

Tumbleform                      Feeder seat                      Stander                      Prone wedge  
                    Sidelyer                      Other

**Transportation:**

Van    SUV    Sedan                      Carseat                      Tie-downs                      Lift                      Ramp

**Orthotics:**

Hand splints                      Foot/ankle orthotics                      Trunk orthotic

**Recreation and leisure aids:**

**Other:**