PEDIATRIC HELPING HANDS THERAPY

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Medical History

Pregnancy/Delivery:
Pregnancy proceeded: ___Normally ___With complications
Delivery proceeded: ___Normally ___With complications
Prenatal care was: ___Received ___Not received
Delivery was: ___Vaginal ___C-Section
Length of Pregnancy: _____
Child's length of hospital stay: _____

Pregnancy Complications (Select all that apply)**:**

___Eclampsia
___Gestational Diabetes
___Multiple Births
___Polyhydramnios
___Positive for Cytomegalovirus (CMV)
___Positive for Herpes
___Positive for Strep B
___Pre-eclampsia
___Pre-mature Labor
___Substance Exposure
___Toxemia
___Positive for HIV
___Other (Please specify): _____

Delivery Complications (Select all that apply)**:**

___Abruptio Placenta
___Breech presentation
___Low birth weight
___Negative Vacuum
___Non-progressive/Unproductive labor
___Occiput posterior position (face up)
___ Placenta Previa
___ Premature Rupture of Membranes
___ Transverse presentation
___Prolapsed Cord
___Use of forceps
___ Uterine rupture
___Umbilical cord around neck
___Other (Please specify): _____

Birth Information:
Mother's age at time of birth: _____
Birth Hospital: _____
Transferred to other hospital? ___Yes ___No Transfer hospital: _____
Additional Comments: _____

Birth Weight: _____ Birth Height: _____
Apgar Scores: 1 minute_____ 5 minutes_____ 10 minutes_____

Multiple Child Pregnancies:
Number of live births: _____ Number of still births:_____
Additional Details: _____

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Complications following birth (Select all that apply)**:**

___Anemia of Prematurity
___Bronchopulminary Dysplasia (BPD)
___Cleft lip
___Cleft palate
___Club foot
___Cytomegalovirus (CMV)
___ECMO
___Failure to Thrive
___Hyperbilirubinemia
___Intrauterine Growth Retardation (IUGR)
___IVH Bleed Grade 1
___IVH Bleed Grade 2
___IVH Bleed Grade 3
___IVH Bleed Grade 4
___Jaundice
___Meconium Aspiration
___Necrotizing Enterocolitis
___Neonatal Hypoxia
___Oxygen dependency
___PDA
___Positive dependency
___Respiratory Distress Syndrome
___Respiratory Stridor
___Respiratory Syncytial Virus (RSV)
___Thrombocytopenia (low platelet count)
___Ventilator Dependency
___VP Shunt
___Other (Please specify): _____

Diagnosed/Suspected Syndromes: _____

Medications/Allergies

Current medications: _____

_____

Allergies: _____

_____

Current vitamins, herbs, minerals, homeopathic: _____

_____

Hearing Testing:

Test results: ___Normal ___Abnormal ___Never tested
Last test date: _____
Results: _____

Vision Testing:

Test results: ___Normal ___Abnormal ___Never tested
Last test date: _____
Results: _____

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Physician	Specialty	Reason	Last Date of Visit

Surgery/Procedure/Diagnostic Tests	Details/Results	Date

Medical Conditions (Select all that apply)**:**

___Allergies
___Arteriovenous Malformation (AVM)
___Anoxic brain injury
___Asthma/Respiratory breathing problems
___Autism
___Baclofen pump
___Cerebral Palsy
___Cerebral Vascular Accident (CVA)
___Chronic ear infections
___Colic
___Constipation
___Diarrhea
___Down Syndrome
___Hip subluxation (Degrees: _____)
___ Hydrocele
___Laryngomalacia
___Muscular Dystrophy
___Osteoporosis
___Periventricular Leukomalacia
___Reflux
___Seizure condition
___Scoliosis (Degrees:_____)
___Sleep disorder
___Sleep problems
___Shunts
___Torticollis
___Traumatic Brain Injury (TBI)
___Tube feeding
___Tubes in ears
___Vagal nerve stimulator

Other medical/orthopedic conditions: _____

_____

_____

Additional comments: _____

_____

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Developmental History

Motor/Play

When did the child begin:
Bringing both hands to mouth? _____
Buttoning pants/shirts? _____
Come to sitting from lying with assistance? _____
Creeping or crawling alone? _____
Fully toilet trained? _____
Grabbing a toy? _____
Holding head up alone? _____
Pulling self to standing position? _____
Rolling over? _____
Self-bathing? _____
Self-dressing? _____
Sitting alone without support? _____
Standing unsupported? _____
Tying shoes? _____
Walking with support? _____
Walking unaided? _____
Zipping/unzipping jacket? _____

Comments/Concerns: _____
_____
_____

Is the child:
___Right handed
___Left handed
___No hand preference

Are there handwriting concerns? ___Yes ___No

The child primarily gets around the home by: _____
The child's favorite toys and play activities are: _____
_____

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Description of the child (Select all that apply)**:**

___Active
___Affectionate
___Aggressive
___Calm
___Cautious
___Curious
___Demanding
___Difficult to comfort
___Distractible
___Fearful
___Fearless
___Fussy
___Insecure
___Motivated
___Passive
___Persistent
___Playful
___Shy
___Stubborn
___Withdrawn
___Other (Please specify): _____

Sensory/Socio-emotional

Sensory Processing/Regulation (Select all that apply)**:**

___Avoids getting messy
___Seeks out (craves) touch or movement
___Stumbles or falls frequently
___Appears awkward or less coordinated
___Flaps hands
___Allows brushing of teeth
___Bangs on surfaces; bangs or hits head
___Fatigues quickly
___Has self-abusive behaviors
___Resists certain tasks or environments
___Spins things or self
___Is sensitive to lights, sounds, or noise
___Sleeps a lot
___Resists touch
___Walks on toes
___Lines up toys or objects
___Seeks out (craves) visually stimulating objects
___Seeks out (craves) stimulating sounds
___Resists certain movements (e.g. bouncing, swinging)
___Has difficulty figuring out how to move body
___Can't tolerate certain textures (e.g. clothing, food)
___Uses too much pressure to touch or hold things
___Has difficulty transitioning between activities
___Has difficulty falling asleep
___Has difficulty remaining asleep through the night
___Appears lethargic or sleep all the time
___Has poor sense of body in space
___Seeks support on furniture, walls, people, etc.
___Demonstrates stiff or rigid movement patterns
___Hyper-focused on specific tasks, people, objects
___Other (Please specify): _____

Social/Emotional Skills (Select all that apply)**:**

___Is easily distracted
___Calms self easily
___Gets angry/frustrated easily
___Is aggressive towards others
___Prone to emotional outbursts
___Doesn't allow others to join in play
___Has difficulty making friends
___Plays with peers
___Only plays with adults
___Prefers to play alone
___Has difficulty with separations
___Has poor eye contact
___Other (Please specify): _____

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Feeding

Describe any current feeding problems: _____

_____

Food preferences: _____

Food dislikes: _____

When did the child begin:

Using a bottle_____
Using a pacifier_____
Eating baby food_____
Eating junior food_____
Eating table food_____
Drinking from a cup_____
Using a straw_____
Stop using a bottle_____
Stop using a pacifier_____
Using utensils to eat_____
Holding own bottle/cup_____
Self-feeding_____

Current feeding adaptations:

___Thickened liquids: _____
___Adapted utensils: _____
___Adapted seating: _____
___Calorie supplements: _____
___Tube feeding: Amount _____; Times per day _____

Breastfeeding:

___Currently: Times per day _____
___Weaned: At age: _____
___Never

Areas of difficulty:

___Chewing
___Communication needs
___Transitioning between foods
___Jaw shifts/slides/juts
___Drooling
___Swallowing
___Understanding words

Speech/Language

Communication skills:

Does the child
Have speech that is understood by most people? ___Yes ___No
Respond correctly to yes/no questions? ___Yes ___No
Follow simple instructions? ___Yes ___No
Respond when name is called? ___Yes ___No
Stutter? ___Yes ___No
Recognize objects, people, and places? ___Yes ___No
The child's primary method of communication is ___Verbal ___Non-verbal
Is an augmentative communication device used? _____

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When did the child begin:

Babbling _____ Putting two words together _____
Saying first words _____ Using short sentences _____
Naming familiar objects _____
What were the child's first words? _____

Primary method of verbal communication (Select all that apply)**:**

___None ___2 word phrases
___Vocalizations ___Complete sentences
___Single word phrases

Primary method of nonverbal communication (Select all that apply)**:**

___Facial expression ___Gestures
___Body language ___Pointing
___Sign language ___Eye gaze
Communication concerns: _____

<u>Home Environment</u>

Child lives with:
___Birth mother ___Birth father ___Step mother ___Step father ___Grandmother ___Grandfather
___Siblings (Ages:_____) ___Other relative: _____
___Legal guardian: _____
Comments/Other details: _____

Adoption (If applicable)**:**

Age of child at adoption: _____
Details of adoption: _____

Type of home:

___Single level home ___Assisted living facility
___2 level home ___Skilled nursing facility
___Ground floor apartment ___Group home
___Upper level apartment ___Other: _____

Accessibility:

___Stairs to enter home: How many? _____ Handrail? _____
___Ramp to enter home
___Stairs inside home: How many? _____ Handrail?
Bedroom on ___Main level ___Upper level
Bathroom on ___Main level ___Upper level

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Equipment (Select all that apply)**:**

___Braces ___Walker ___Stander ___Manual wheelchair ___Power wheelchair ___Hoyer lift
___Weighted vest ___Hand splints ___Track system ___Other:_____

Do you currently perform a home program with your child (e.g. stretching, strengthening, brushing protocol)? ___Yes ___No
If so, please describe: _____
_____

Is the child involved in any community groups or sporting activities? ___Yes ___No
If so, please describe: _____
_____

Therapy/School History

Grade in school: _____ Where: _____
Does your child have an IFSP?: ___Yes ___No
Does your child have an IEP from school? ___Yes ___No
Has your child had a psychological or neuropsychological evaluation completed? ___Yes ___No

Service	Group/Individual	Status	Frequency	Location/Setting
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental Therapy				
EI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Work				
Speech/Language Therapy				
Developmental Follow-Up Clinic				
Other: _____				
Other: _____				

Comments/Additional Details:_____
_____
_____