Providing services in:
Physical Therapy
Occupational Therapy
Speech/Language Pathology
Hydrotherapy
Special Therapy Programs

PATIENT EVALUATION FORM - CHILD

Date:______________

Name:____ DOB:______________ Age:_______
Diagnoses (of any kind): ____
____

Reason for evaluation –
Parental concerns: ____
____
Recommendation from other professional(s)/parent(s)? What concerns were shared with you and by whom? ____
____
____

GENERAL INFORMATION:

Please list any allergies, medications, dietary guidelines, or medical precautions for your child:

Has your child received speech, occupational, or physical therapy in a medical setting? Does your child currently receive any of these services through your school district? If so, please specify where and when.

Has your child received cognitive/intelligence/psychological testing? If so, further explain and specify when.

Has your child received a hearing screen or formal hearing evaluation? If so, further explain and specify when.

Has your child received a vision screen or formal vision evaluation? If so, further explain and specify when.

If you have the results of these evaluations, please attach.

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FAMILY HISTORY:

Parent's name:___________________________ Parent's name:___________________________
Parent's name:___________________________ Parent's name:___________________________

Siblings Name and Age:
____
____

Who currently lives with this child?
____
____

Please answer the following questions to the best of your ability and make comments as appropriate.

Medical History Prior to Birth: 1. Were there any illnesses, injuries, bleeding, operations, or any difficulties?	YES	NO	COMMENTS
2. Was the pregnancy full-term? If not, please give weeks and weight.			
	YES	NO	COMMENTS
Medical History: 3. Was the delivery (vaginal, breech, caesarian)? Please specify.			
4. What was the approx. length of labor?			
5. Were forceps or suctioning used?			
6. What was the child's birth weight?			
7. Were there any complications following birth including needing oxygen or additional respiratory assistance, transfusions, tube feedings, etc?			
8. Was the length of the infant's stay in the hospital unusually long? If so, why?			
9. Were there any feeding difficulties after birth including problems sucking or nutrient intake? Please specify.			
10. Was the child bottle-fed?			
11. Has your child had any significant childhood illnesses? If so, please be specific.			

12. Does your child experience frequent ear infections?			
13. Does your child have P.E. tubes? Permanent or temporary? If so, what ears?			
14. Has your child had the following immunizations? Please give dates and indicate whether the child had the illness or was immunized.			
a. Measles			
b. Mumps			
c. Whooping Cough			
d. Hepatitis B			
e. DPTAP			
f. Others (i.e. Chicken pox, etc)			
	YES	NO	COMMENTS
15. Does your child have a hearing problem?			
16. Is your child currently on any medications? If yes, please list and state reason.			
17. Has your child had toxicity testing? If so, what were the results?			
18. Does your child use any adaptive equipment? Please specify.			
19. Do you have any home therapy equipment (i.e. Trampoline, swing, etc.)? Please specify.			
Developmental History: 20. Did your child do the following: (please specify ages as near as possible) a. roll over from stomach to back?	YES	NO	AGE
b. roll over from back to stomach?			
c. sit independently?			
d. crawl?			
e. cruise around furniture?			
f. walk?			
g. speak his/her first word? what was it?			
h. speak combined words?			
i. speak his/her first sentence?			
j. drink from a cup independently?			
k. feed self independently? what type of utensils?			
l. dress self independently?			

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	YES	NO	COMMENTS
24. Describe your child at present:			
a. is mostly quiet			
b. is overly active			
c. tires easily			
d. talks constantly			
e. impulsive			
f. is stubborn			
g. is resistant to changes			
h. over reacts			
i. fights frequently			
j. is usually happy			
k. exhibits frequent temper tantrums			
l. is clumsy			
m. has difficulty separating from primary caretaker			
n. has nervous habits or tics			
o. falls often			
p. wets the bed			
q. has poor attention span			
r. is frustrated easily			
s. has unusual fears			
t. rocks self frequently			
u. has difficulty learning new tasks (i.e. writing, throwing a ball, riding a bike, etc)			
v. explores and plays with toys appropriately			

Speech/Language History:

25. Please describe the concerns you have regarding your child's speech and/or language. Give examples of their difficulties.

26. How does your child make his/her needs and wants known?

27. Please describe when you first noticed something was different about the way your child communicates. When did the change occur and what do you think brought on the change?

28. Does our child play with toys differently than his or her peers? Please describe the difference.

29. Is there any history of speech, language or stuttering difficulties in your family? If so, who and what is their relationship to the child.

Family History:

30. Do any of your child's siblings receive therapy services or have a related diagnosis?

31. Is there a family history of any other related medical (physical or emotional) conditions? If so, what is their relation to the child?

Educational History:

32. Does your child currently attend school? If yes, please provide name of school, contact person, and fax number so a school intake questionnaire can be sent. Please fill out release form.

33. Does your child have an IEP, IIIP, or IFSP? Please enclose copy of current evaluation and education plan.

Additional Questions:

35. What does your child like to do?

36. What does your child dislike?

37. Is your child currently active in any extracurricular/recreational activities? If so, what

Goal Areas:

34. In the next several months, I would like my child to be able to:

In the area of speech/language (ex "talk clearly, use more words, follow directions. . .")

In the area of occupational therapy (ex "dress independently, tolerate more sensory experiences, use his/her hands better…")

In the area of physical therapy (ex "kick or catch a ball, stand on one foot, run, hop, skip, jump, have more mobility…")

39. Additional comments, questions or concerns.

Thank you for taking the time to complete this form. It is greatly appreciated and will be helpful in completing your child's evaluation here at Family Achievement Center.

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