



4602 Cumberland Road
Fayetteville, NC 28306
Phone (910) 423-5622
Fax (910) 378-1755

Date: _____

IDENTIFYING INFORMATION

Child's Name: _____ Child's DOB: _____

Parent/Guardian Names: _____

If you are a guardian, do you have custody papers, DSS care, foster care, or power of attorney? _____
If yes, please provide a copy for our records.

Street Address: _____ City: _____ Zip Code: _____

Who else lives in the home with your child? _____

Primary Contact Number: _____ Secondary Contact Number: _____

Cell Service Provider: _____ Email address: _____

How would you like to receive appointment reminders? EMAIL PRIMARY CONTACT NUMBER

Primary Care Physician & Clinic: _____

Primary Insurance Provider: _____ Secondary Insurance Provider: _____

Policy Holder: _____ Policy Holder: _____

Policy Number: _____ Policy Number: _____

Sponsor's SSN *Tricare only*: _____ Sponsor's SSN *Tricare only*: _____

What are the doctor's/teacher's concerns regarding your child's development? _____

What are your concerns regarding your child's development? _____

How does your child communicate wants and needs? Please check all that apply.

_____ Crying _____ Pulling/leading _____ One word _____ Long sentences
_____ Pointing _____ Making sounds _____ Short sentences _____ Other: _____

What language(s) is your child exposed to? _____

MEDICAL & DEVELOPMENTAL HISTORY

Were there any pregnancy complications? _____ If yes, please explain. _____

Length of pregnancy: _____ Was prenatal care received? _____ Mother's age at birth: _____

Were there any delivery complications? _____ If yes, please explain. _____

The delivery was (please mark all that apply)
_____ Induced _____ Vaginal _____ C-Section _____ Emergency C-Section

Number of days in hospital following delivery: _____ Birth Weight: _____ Birth Height: _____

What hospital was your child born at? _____

Was your child transferred to another hospital? _____ If yes, where? _____

Did your child have any complications following delivery? _____ If yes, please explain. _____

Does your child have any medical diagnoses or medical concerns? _____ If yes, please explain. _____

List all allergies (seasonal, food, medications, etc): _____

Please list any medications, vitamins, or supplements the child is currently taking (or recently took, if pertinent):

Medication	Reason

Has your child had any ear infections? _____ If yes, how many and when? _____

Date of most recent hearing evaluation: _____ Did your child pass? _____

Do you have concerns with your child's hearing? _____ If yes, please explain. _____

Date of most recent vision evaluation: _____ Did your child pass? _____

Do you have concerns with your child's vision? _____ If yes, please explain. _____

Has your child ever been hospitalized? _____ If yes, please complete the box below.

When	How long	Reason

Is your child followed by any medical specialist? _____ If yes, please complete the box below.

Specialty Area	Doctor's Name/Clinic	Reason

Has your child ever received any diagnostic testing? _____ If yes, please complete the box below.

Type of Test	When	Summary of Results

Has your child had any surgeries? _____ If yes, please complete the box below.

Type of Surgery	When	Reason/Complications

Please list the age that your child met the following milestones:

_____ Supported head independently _____ Sat up alone _____ Said first word
 _____ Reached for objects _____ Crawled _____ Put 2 words together
 _____ Rolled over _____ Walked without support _____ Potty trained

Please circle an answer for the following statements:

Does your child fall or lose balance easily?	(YES)	(NO)	
What hand does your child use to write?	(LEFT)	(RIGHT)	(UNKNOWN)
Child visually looks at people/toys?	(YES)	(NO)	
Child shows negative response when touched or touching other objects?	(YES)	(NO)	
Child enjoys movement such as swinging or roughhousing?	(YES)	(NO)	
Child play/participate in leisure activities daily?	(YES)	(NO)	
Child involved in community programs?	(YES)	(NO)	
Do most people understand the child?	(YES)	(NO)	
Does the child understand instructions?	(YES)	(NO)	

Did your child have difficulty latching or accepting a bottle following birth? _____ If yes, please explain how the child was fed. _____

Can your child feed him/herself? _____ If no, who feeds your child? _____

Does your child accept food from utensils? _____ If no, how does he/she eat food? _____

What does your child drink from? Please check all that apply.

_____ bottle _____ sippy cup _____ straw cup _____ open cup _____ other: _____

Will your child eat foods from the following food groups? If yes, please check.

_____ meats _____ dairy _____ vegetables _____ fruits _____ grains

Is your child on a special or restrictive diet? _____ If yes, please explain. _____

Will your child accept the following food consistencies? Please check all that apply.

_____ pureed food

ex: applesauce

_____ mixed textures

ex: cereal & milk

_____ hot food

ex: oatmeal

_____ crunchy food

ex: chips

_____ chewy food

ex: gummy snacks

_____ cold food

ex: ice cream

Do you have any concerns regarding eating or feeding skills? _____ If yes, please explain. _____

Does your child attend daycare or school? _____ If yes, please list where and what grade. _____

Does the child have an IEP? _____ If yes, we will need an updated copy.

Does your child have an IFSP through North Carolina CDSA? _____ If yes, please complete the box below. *Birth to 3 years old only. If yes, we will need an updated copy.*

Who is your service coordinator?	
Where will the child receive services? <i>Only if qualifying for play, speech, or feeding.</i>	Location: Address:
Who may the therapist provide information to following sessions?	
If services are rendered in the home, are there pets?	
If services are rendered in the home, are there guns?	

Has your child currently or previously received any therapy services (play, ABA, OT, PT, speech, etc.)? _____ If yes, please complete the box below.

Type of Therapy	Where	When	Frequency/Duration	Reason

Please use this space if you had insufficient room to answer questions or if there is pertinent information regarding your child that you would like to add.
