Stepping Stones
Therapy Network

CLIENT HISTORY QUESTIONNAIRE

Thank you for taking the time to fill out this form as completely as possible. The information you provide plays an important role in the evaluation process. All of your information is confidential and will not be released without your permission. Please attach any additional information, assessments or reports that you would like to share.

Today's Date: _____

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

Diagnosis: _____ **Child's Physician:** _____

How did you hear about Stepping Stones Therapy Network? _____

Name of person completing this form: _____

This child is my: biological child adopted child foster child step child other: _____

What do you hope to gain from this screening/evaluation? What are your specific concerns?

_____

_____

Has your child had an occupational therapy evaluation before? Yes No

If Yes, where and when? _____

**Please include a copy of any other recent evaluations or therapy assessments.*

FAMILY BACKGROUND

Name of PARENTS/GUARDIANS	Relationship to Child	Living with this Child?
		Yes No
		Yes No
		Yes No
Names of OTHER FAMILY MEMBERS Living in the Home	**Relationship to Child**	**Age**

Does anyone related to this child have speech, language, learning, reading or physical development problems?

If Yes, please explain? _____

_____

HEALTH/MEDICAL HISTORY

Date of last physical exam: _____ **Completed by Dr.:** _____

Has your child seen the following specialists? Please check all that apply.

Neurologist
Psychiatrist
Psychologist
Orthopedic Surgeon
Ear/Nose/Throat Specialist
Ophthalmologist/Vision
ABA Therapist
Speech Therapist
Physical Therapist

List Any MEDICATIONS Your Child Is Currently Taking	For What Condition	Explain Any Side Effects

Please describe any unusual medical conditions or events that occurred:

During Pregnancy:
At Birth:
Immediately After Birth:
First 12 months of life:
After first year: _____
Birth weight:_____ **Was the pregnancy of typical duration (40 wks)?** Yes No
If No, please explain duration/conditions of pregnancy:

_____

List Your Child's ALLERGIES		List Your Child's MEDICAL CONDITIONS

Has your child ever been hospitalized? Yes No **If Yes, please explain:**

_____

HEARING:		
Please explain any concerns regarding your child's hearing.		
Does your child have a history of frequent ear infections? If so, please list ages.	Yes No	Ages:
When & where was his/her last hearing test?		
Results of last hearing test		
VISION:		
Please explain any concerns regarding your child's vision.		
When & where was his/her last vision test?		
Results of last vision test		

DEVELOPMENTAL HISTORY

Please give approximate ages your child achieved the following milestones:		
Sat Alone:	Crawled (hands/knees):	Walked Independently:

MOTOR SKILLS: **Do you have any concerns regarding your child's coordination while doing the following tasks?**	**YES**	**NO**	**COMMENTS**
Walking			
Walking up/down stairs			
Feeding him/herself			
Toilet Training			
Dressing			
Clothing fasteners (buttons, zippers, shoe tying)			
Riding a tricycle/bike			
Jumping			
Running			
Coloring			
Writing legibility			
Cutting with scissors			
Does your child demonstrate hand dominance?			Right Left
Is your child able to play physical games as well as most children of the same age?			

SENSORY PROCESSING: Do any of the following statements describe your child?	YES	NO	COMMENTS
Fearful of movement (swings, when feet are off the ground, etc.)			
Constantly in motion			
Bothered by certain types of clothing/touch/textures			
Frequently touches people/objects			
Rough with people/toys			
Frequently irritable/fussy			
Has difficulty transitioning to new activities			
Seems to enjoy strange or loud noises			
Dislikes certain noises			
Rubs or covers his/her ears			
Has a hard time paying attention			
Described as clumsy			
Fatigues easily			
Has strong food preferences			

Additional Comments or Concerns:

SOCIAL AND EMOTIONAL DEVELOPMENT

How would you describe your child's personality?

Does your child play socially with other children?

BEHAVIOR: Do you have any concerns in the following areas?	YES	NO	COMMENTS
Eye contact			
Peer interactions			
Paying attention			
Following directions			
Aggression			
Frustration Tolerance			
Impulsivity			
Other			

What are your child's favorite toys/activities?

Academic/Therapy History

Does your child attend school? Yes No **Name of School:** _____

Grade:_____ **Teacher:**_____ **School District:**_____

Services At School?: If your child receives the following services **at school**, please check all that apply:

Special Education Classes Occupational Therapy Speech Therapy Physical Therapy

List other therapists/specialists your child has seen:

Name of Therapist	Type of Treatment	Dates of Service (Month/Year)

COMMUNICATION DEVELOPMENT

Has your child had a speech and language therapy evaluation before? Yes No

If Yes, where and when? _____

** Please include a copy of any other recent evaluations or therapy assessments.*

Do you have any concerns regarding speech or communication? Yes No

If Yes, please complete the following questions:

LANGUAGE **How does your child communicate?**	**YES**	**NO**	**COMMENTS / EXAMPLES**
Gestures			
Single words			
Combination of 2 words			
Short phrases			
Sentences			
Approximately how many words does your child speak?	-----	-----	
Makes eye contact while communicating			
Understands simple questions/directions			
Can follow 1-2 step directions (Please give example.)			
Attention span is decreased in listening situations			
FLUENCY	**YES**	**NO**	**COMMENTS / EXAMPLES**
Stutters			
Stammers			
Gets 'stuck' when speaking			
ARTICULATION & SOUND CLARITY	**YES**	**NO**	**COMMENTS / EXAMPLES**
My child sounds like other children of the same age.			
There are concerns with how clearly my child says particular sounds or letters.			
Other people have trouble understanding my child. (Please explain.)			
My child is aware of his/her communication difficulties.			
My child responds to speech and different sounds in the environment.			
WRITTEN & ORAL EXPRESSION	**YES**	**NO**	**COMMENTS / EXAMPLES**
Has difficulty expressing basic thoughts			
Verbalized thoughts lack specific detail			
Poor grammar skills			
Has trouble with starting and/or organizing ideas			
READING COMPREHENSION	**YES**	**NO**	**COMMENTS / EXAMPLES**
Difficulty understanding material that has been read			
Difficulty using phonics skills to decode unfamiliar words			
Reading is slow or choppy			
Feels overwhelmed with textbook reading			
ORAL MOTOR/FEEDING	**YES**	**NO**	**COMMENTS / EXAMPLES**
Do you have any concerns regarding your child's feeding or eating habits? (If so, please explain.)			

**** Please attach any additional information or recent assessments/reports that you would like to share. ****