Mail or Fax to

Children's Neurotherapy Services

1087 13th Street SE, Hickory, NC 28602

Fax: 828-267-1690 Phone: 828-267-1688

Sensory and Developmental History

General Information/History

Name:____ Date of Birth:_____________________

Last First MI Month Day Year

Mother's Name:_____________________________ Father's name:____________________________

Siblings Name/Age: ____

____

____

$ Is your child involved in:

___Preschool:____

___Early Intervention Program: ____________________________

$ Is your child currently receiving occupational therapy services? If yes, when and where?

____

(If you consent, please send CNS copies of therapy evaluations and other reports.)

Medical Information/History

$ Child's Physician: ____

Address/Phone:____

Please list any other physicians your child has seen, when and why: ___________________

____

____

$ Medical Diagnosis (if known): ____

$ Testing performed? ___Vision (date____________) ___Hearing (date__________)

___Genetic (date___________) ___Allergy (date__________)

Results: ____

____

____

$ Please indicate, describe, and provide approximate dates for the following pertaining to your child:

Allergies:____

Casts or braces:____

Childhood disease or major illness: ____________________________

Congenital Abnormalities: ____________________________________

Ear infections:____

Injections (Botox, phenol or other?): ___________________________

Seizures: ____

Serious injury:____

Surgery:____

Tubes in ears: ____

Other: ____

$ Please list medications current and past (with reason for taking) for your child:

Current medications:____

Past medications: ____

$ Please list medical precautions (if any) regarding your child and therapy:_______________

$ Please list other evaluations or treatment (neurological, speech/language, psychological...) your child has received below:

Treatment *Dates Received* *By whom*

*

*

*

*____
(If you consent, please send CNS copies of these evaluations and/or reports.)

Mother's Pregnancy History

$ Did the mother?
1. Experience any infections/illnesses during pregnancy? Y/N If yes, please describe:
____
____
2. Experience any unusual stress/anxiety during pregnancy? Y/N
3. Take any medications during pregnancy? Y/N If yes, please indicate:___________
____
4. Experience any complications during delivery/labor process? Y/N If yes, please describe: ____
____

Child's Birth

$ Full term or Premature? (Circle one.)
$ Number of weeks:_______________
$ Weight at birth:________________
$ Small for gestational age? Y/N
$ Apgar score (if known) at one minute:_______ at five minutes:_______.
$ Breech (feet first) Y/N
$ Required forceps for delivery? Y/N
$ Birth injuries? Y/N If yes, please describe: __________________________________
____
$ Required Intensive Care Hospitalization? Y/N If yes, length of treatment:______________________________________
$ Jaundiced? Y/N If yes, length of treatment:______________________________________

Infancy and Early Childhood

$ Does or did this child?
1. Experience feeding problems/difficulties? Y/N If yes, please describe: __________
____
2. Experience sleeping problems/difficulties? Y/N If yes, please describe:__________
____
3. Experience colic? Y/N If yes, indicate length: ____________________________
4. Prefer certain positions as an infant? Y/N If yes, please indicate: _______________
____
5. Dislike lying on stomach? Y/N On back? Y/N
6. Arch back when held and pull away? Y/N
7. Enjoy bouncing? Y/N
8. Become calmed by car rides or infant swings? Y/N

9. Nauseated by car rides or infant swings? Y/N
10. Tend to always be generally compliant? Y/N
11. Go through “terrible two’s”? Y/N

Developmental Milestones

$ Provide the approximate ages (when possible) or comment on anything unusual for the following:

1. Rolling over: ____
2. Comes to sit alone:____
3. Drinks from a cup:____
4. Says words: ____
5. Chews solid food: ____
6. Crawls on all fours: ____
7. Walks: ____
8. Says sentences:____
9. Maintains sitting during play: _______________________________
10. Was crawling phase brief? Y/N Absent? Y/N
11. Does or did child use a walker (rolling plastic seat)? Y/N
12. Does or did child experience hesitancy or delays in learning to go down stairs? Y/N
13. Did child climb out of crib independently? Y/N If yes, at what age: _____________

Sensory/Motor History

Have the behaviors described below existed in the past or exist presently? Please circle the appropriate: O = often; S = sometimes; R = rarely/never; and comment as available. Cross out any part of the question that does not apply.

Visual Processing

$ Does or did child?

1. Withdraw from bright lights?	O	S	R	______________________
2. Seem to be distracted by lights?	O	S	R	______________________
3. Seek out/regard bright lights?	O	S	R	______________________
4. Like to play in small spaces?	O	S	R	______________________
5. Like having head covered?	O	S	R	______________________

Auditory and Language Processing

$ Does or did child?

1. Like music?	O	S	R	______________________
2. Sing along with music?	O	S	R	______________________
3. Seem overly sensitive to sounds?	O	S	R	______________________
4. Seem distracted by noise or sounds?	O	S	R	______________________
5. Seem distracted by background noise				

(refrigerators, fans, flourescent lights...) O S R ____________

6. Have articulation difficulties? O S R ____________

Movement

$ Does or did child?

1. Enjoy swings? O S R ____________
2. Like being tipped upside down or lifted overhead? O S R ____________
3. Seem fearful of balls thrown toward him/her? O S R ____________
4. Bang head on purpose? O S R ____________
5. Like to be spun around or spins self on swings, sit-n-spin? O S R ____________
6. Become carsick easily? O S R ____________
7. Fall asleep easily in car? O S R ____________
8. Enjoy bouncing? O S R ____________

Taste and Smell

$ Does or did child?

1. Tend to explore with smell, deliberately smell objects? O S R ____________
2. React defensively or seem overly sensitive to some odors? O S R ____________
3. React defensively to taste and texture of many foods? O S R ____________
4. Act as though all food tastes the same? O S R ____________
5. Have more difficulty eating textured than smooth foods? What items? O S R ____________
6. Prefer crunchy textured foods? O S R ____________
7. Have difficulty eating smooth foods with a few lumps (soup, fruit, yogurt)? O S R ____________
8. Lick, suck or chew on non-food items (past 18 months)? O S R ____________
9. What food does the child prefer? ________________________

____

Tactile/Touch

$ Does or did child?

1. Seem excessively ticklish? O S R ____________
2. Become irritated by tags in clothing? O S R ____________
3. Dislike fingernail/toenail cutting? O S R ____________
4. Dislike wearing hats or mittens? O S R ____________
5. Complain if socks are not on correctly? O S R ____________
6. Seem to crave being held or cuddled? O S R ____________

7. Tend to prefer long sleeves and pants regardless of weather? O S R ______________________
8. Dislike cloth of certain textures (blue jeans, plastic bibs...) O S R ______________________
9. Avoid getting hands into food, paste, finger paints, or messy things? O S R ______________________
10. Tend to be more sensitive to pain than others? O S R ______________________
11. Become especially bothered by small cuts? O S R ______________________
12. Tend not to feel pain as much as others? O S R ______________________
13. Pinch, bite or otherwise hurt self? O S R ______________________
14. Complain about irritating bumps on bed sheets? O S R ______________________
15. Become upset when coming out of a bath? O S R ______________________
16. Become extremely irritated when splashed with water? O S R ______________________
17. Mouth objects or clothing frequently? O S R ______________________
18. Seem overly sensitive to food or water temperature? O S R ______________________
19. Dislikes tooth brushing? O S R ______________________
20. Dislikes wearing band-aids or stickers? O S R ______________________

Social

$ Please describe child's socialization skills: ____
____
____

Motor Skills

$ How does child move in his/her environment?____________________________________
____
$ What interferes most with child's movement/mobility?______________________________
____
$ Are there steps in or outside child's home? Y/N
$ How is your child seated when eating?____
$ Does child use any special utensils, plates, cups? Y/N If yes, what? ________________
____
$ Does child drink from a straw? Y/N

$ Does or did child:

		O	S	R	
1.	Have difficulty with handling eating utensils?	O	S	R	____________________
2.	Tend to eat in a sloppy manner?	O	S	R	____________________
3.	Tend to drool (past 11 months)?	O	S	R	____________________
4.	Keep mouth open most of the time?	O	S	R	____________________
5.	Have trouble chewing?	O	S	R	____________________
6.	Have difficulty giving a kiss?	O	S	R	____________________

Play Behavior

$ What are the child's favorite play things? ____

____

$ What does he/she do with these toys?____

____

$ Who does child prefer to play with?____

$ What activities does the child least enjoy?_______________________________________

____

$ How long does child play with one toy?____

$ Does child tend to play in one body position more than others? Y/N If yes, which positions? ____

$ Does child tend to play with things by lining them or piling them up (if over two years of age)? Y/N

$ Are there any things which your child tends to fear or avoid? Y/N If yes, please describe: ____

____

$ Has your child been involved in any extra-curricular activities (Gym-Boree, swimming lessons...)?____

____

$ Does your child have a computer, Nintendo or Sega? Y/N

Bowel and Bladder

$ Is child toilet trained? Y/N

$ At what age did child:

1. Indicate discomfort of soiled pants? ___________________________________
2. Anticipate need to eliminate?____
3. Indicate need to use toilet?____
4. Begin toilet training? ____

$ Does or did child:

1. Continue to have accidents during the day? Y/N If no, at what age trained?_______
2. Continue to have accidents during the night? Y/N If no, at what age trained?_____
3. Seem fearful of sitting on toilet? Y/N

Sleep Patterns

$ Does child:

1. Have regular sleep patterns? Y/N Please describe:____________________________
____
2. Wake frequently during the night? Y/N If yes, please describe:_________________
____
3. Tend to be an early riser, up and on the go? Y/N
4. Have a difficult time falling asleep? Y/N

Equipment

$ What (if any) special equipment does the child have? ______________________________
____

$ Is all of it used? Y/N If not, which pieces and why?______________________________
____

Orthotics

$ Please list any orthotics used and wearing schedules: ______________________________
____
____

Splints

$ Please list any splints used and wearing schedules: ________________________________
____
____

Muscle Stiffness

$ Does the stiffness of child's muscles complicate dressing, bathing, diaper changes..? Y/N

Family History

$ Handedness:

R/L Mother
R/L Father
R/L Siblings
R/L Grandparents
R/L Others____

$ Does anyone else in the family have similar difficulties as this child? Y/N

$ What particular skills would you like this child to achieve in the next six months? ______
____
____
____

$ What do you hope to gain from this evaluation and/or treatment?

Signature of Parent or Guardian

Date