CHILDREN'S
NEUROTHERAPY SERVICES, LLC
www.cnsclinic.com
CNS Clinic
1087 13th St SE Hickory, NC 28602 - 4165 **OFFICE** (828) 267-1688 **FAX** (828) 267-1690

# Sensory and Developmental History

**Name:** _____ **Date of Birth:** _____
Last First Middle Month Day Year

**Mother's Name:** _____ **Father's Name:** _____

**Email Address:** _____

**Child's Physician:** _____

**Child's School:** _____ **Grade:**_____

**Does your child have an Individualized Education Plan (IEP) or 504 Plan at school:☐YES☐NO**

**A copy of your child's IEP or 504 Plan is needed on the day of the evaluation.**

**During the Past six months, has the child been seen by:**

If yes, please explain reason for visit(s):

| | | | |
|---|---|---|---|
| **Medical Doctor:** | ☐ **YES** | ☐ **NO** | _____ |
| **Ear, Nose & Throat Doctor** | ☐ **YES** | ☐ **NO** | _____ |
| **Psychiatrist/Psychologist** | ☐ **YES** | ☐ **NO** | _____ |
| **Neurologist** | ☐ **YES** | ☐ **NO** | _____ |
| **Physical Therapist** | ☐ **YES** | ☐ **NO** | _____ |
| **Occupational Therapist** | ☐ **YES** | ☐ **NO** | _____ |
| **Speech Therapist** | ☐ **YES** | ☐ **NO** | _____ |

**Is your child seeing any other specialist?** If so, whom and for what?

_____

_____

**Please list any medical conditions your child has been diagnosed with:**

_____

_____

_____

**Please list any medications (prescribed or over the counter) your child is currently taking:**

_____

_____

_____

**List any allergies you child has (food and environmental):**

_____

_____

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

**Casts, Braces, Orthotics, Hand Splints:** _____

_____

**Childhood disease or major illness:** _____

_____

**Congenital Abnormalities:** _____

_____

**Ear Infections:** _____

_____

**Injections (Botox, phenol, or other):** _____

_____

**Seizures:** _____

_____

**Serious Injury:** _____

_____

**Surgery:** _____

_____

**Tubes in Ears:** _____

_____

**Any other Special Equipment:** _____

_____

**Other:** _____

_____

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

_____

_____

**Were there any complications with pregnancy, labor, or delivery?** Please explain.

_____

_____

☐ **Full Term** ☐ **Premature?** (Check one)

**Number of weeks:** _____

**Weight at Birth:** _____

**Small for gestational age:** ☐ **YES** ☐ **NO**

**Breech (feet first):** ☐ **YES** ☐ **NO**

**Required forceps for delivery?** ☐ **YES** ☐ **NO**

**Required vacuum for delivery?** ☐ **YES** ☐ **NO**

**Birth Injuries:** ☐ **YES** ☐ **NO**

Please explain: _____

**Required Intensive Care Hospitalization?** ☐ **YES** ☐ **NO**

If yes, length of treatment: _____

**Jaundiced?** ☐ **YES** ☐ **NO**

If yes, length of treatment: _____

**Provide the approximate ages (when possible) or comment on anything usual for the following:**

**Rolling over:** _____

**Sits Independently:** _____

**Crawling:** _____

**Walks:** _____

**Drinks From Cup:** _____

**Says Words:** _____

**Chews Solid Foods:** _____

**Was Crawling Phase Brief?** ☐ **YES** ☐ **NO** **Absent?** ☐ **YES** ☐ **NO**

**Does or did your child experience hesitancy or delays in learning to go down stairs?** ☐ **YES** ☐ **NO**

**At what age was your child toilet trained?** _____

**Does your child continue to have accidents during the day?** ☐ **YES** ☐ **NO**

**Does your child continue to have accidents at night?** ☐ **YES** ☐ **NO**

**Does your child have regular sleep patterns:** ☐ **YES** ☐ **NO**

Please describe: _____

_____

**Tend to be an earlier riser, up and on the go?** ☐ **YES** ☐ **NO**

**Have a difficult time falling asleep?** ☐ **YES** ☐ **NO**

**Need to have an adult present to fall asleep?** ☐ **YES** ☐ **NO**

**Sleep in his/her own bed?** ☐ **YES** ☐ **NO**

**Does your child dislike any types of sensations (touch, noise, lights, movement)? Does he or she seem to seek out any particular sensations?**

_____

_____

_____

**Does your child have any visual or hearing deficits? Have they had a hearing or vision evaluation?** If yes, when?

_____

_____

**Does your child have any feeding/swallowing problems? Problems eating or drinking?**

(Sucking, chewing, drooling, or gagging)

_____

_____

_____

**Does your child have any difficulty with daily skills?** (Dressing, buttons, snaps, shoe tying, eating, using utensils, etc). _____

_____

_____

**Describe the child's problem and when it was first noticed. What are your concerns?**

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

**Additional Comments/Information:**

_____

_____

_____ _____

**Signature of Parent or Guardian:** **Date:**

(Signature Implies consent to treatment)