PATIENT GENERAL INFORMATION FORM

Child's Name: ___________________________________ Date of Birth: ___________________________________

Name of Person Completing Form: __________________________________ Relationship to child: _____________

Please list any siblings/other family members living in the home: ____

____

Birth History

Child was born: FULL TERM or PREMATURE. If premature, how many weeks? ________

Delivery: VAGINAL or WITH FORCEPS or C-SECTION

Please describe any complications during labor and delivery: ____

____

Did your child require any NICU intervention? _____ If so, how long? ________________________

Please describe any other medical problems or complications during your pregnancy or after birth:

____

____

Developmental History

Please mark if your child was "Within Expected Timeframe" or "Has Not Achieved yet" for each of the following:

Milestone	Within Expected Timeframe	Has Not Achieved Yet	Comment
Rolled over			
Sat alone			
Crawled on hands & knees			
Pulled to stand			
Stood unsupported			
Walked alone			
Chewed food			
Drank from a cup			
Finger fed			
Used fork/spoon			
Babbled			
Said Words			
Said sentences			
Toilet trained			
Dressed self			

Medical History

Current Diagnosis: ____

Hospitalizations: YES or NO If yes, please describe:

____

____

Current Medications: ____

Does your child experience seizures, current or in past? ____

Please list any allergies: ____

Family Report

What are your child's strengths? ____

____

____

What are your child's challenges? ____

____

____

What are your goals for your child? ____

____

____

Has your child received Occupational Therapy, Physical Therapy, or Speech Therapy before: ___________________

____

If yes, please indicate the duration of each service listed above: ____

____

Does your child wear glasses? ___________ If yes, please specify: _______________________________________

Educational Information

School/Education Program currently attending ______________________________ Present grade level ________

Does your child receive Special Education services though an IEP _______ 504 Plan ________ RTI Support _______

Does your child's teacher have any concerns? If so, please describe. _______________________________________

____

____

Social/Emotional Development

Does your child interact appropriately with others? YES or NO

Does your child have difficulty making friends? YES or NO

Does your child have difficulty calming himself/herself when upset? YES or NO If yes, please describe:

____

____

Behavior

Please check off any of the following that apply to your child:

	✓	Comments:
Cries often		
Frequent temper tantrums		
Anxious		
Trouble with following directions		
Trouble with changes in routine		
Clumsy		
Weak muscles		
Picky eater		
Mouths objects		
Avoids touch from others		
Dislikes toothbrushing		
Dislikes hair washing/brushing		
Avoids playground equipment		
Sensitive to sound		
Sensitive to light		
Poor attention/focus		
Seeks out movement		

Activities of Daily Living

	Please describe current abilities & level of assistance
Bathing	
Grooming	
Dressing	
Manipulation of Fasteners (buttons/zippers/etc)	
Toileting	
Feeding: Use of Eating Tools	
Meal/Snack Preparation	

Please indicate how you heard about Coleman Pediatric Therapy so that we may thank them for this referral.

- ☐ Physician: ________________________________
- ☐ Health agency: ____________________________
- ☐ Word of Mouth: ___________________________
- ☐ Internet Search Engine: _____________________
- ☐ Coleman Pediatric Therapy Facebook Page
- ☐ Coleman Pediatric Therapy Website
- ☐ Other: __________________________________

We offer appointment notifications through text, email, or both. Please indicate below how you would like to receive these notifications.

Contact #1:

I would like to receive notifications by: ☐ Text only ☐ Email only ☐ Both

Contact Name: _____________________ Cell: ___________________ Email: ____________________________

Contact #2:

I would like to receive notifications by: ☐ Text only ☐ Email only ☐ Both

Contact Name: _____________________ Cell: ___________________ Email: ____________________________

Contact #3:

I would like to receive notifications by: ☐ Text only ☐ Email only ☐ Both

Contact Name: _____________________ Cell: ___________________ Email: ____________________________

We appreciate you taking the time to fill out this questionnaire. This information will help us to become more familiar with your child, thus allowing us to provide the best service possible to you and your child.

____ ____________________________________

Signature (Client 18+/Parent/Legal Guardian) Date