5230 Willow Creek Drive, Ste 101
Springdale, AR 72762

ALL ABOARD PEDIATRIC THERAPY
OT PT ST

900 S. 52nd Street, Ste 103
Rogers, AR 72758

www.allaboardpediatrictherapy.com
Phone (479) 445-6800 | Fax (479) 445-6816

PATIENT INFORMATION

PERSONAL INFORMATION

Today's Date _____

Child's Name _____ [ ] Male [ ] Female

Date of Birth (MM/DD/YYYY) _____ Social Security # _____

Street Address _____ Apt/Suite _____

City _____ State _____ Zip _____

Mother's Name _____ Occupation _____

Mother's SS# _____ Mother's Birthdate _____

Mother's Employer _____ Email _____

Father's Name _____ Occupation _____

Father's SS# _____ Father's Birthdate _____

Father's Employer _____ E-mail _____

Marital Status [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Parental Status [ ] Biological [ ] Adoptive [ ] Foster [ ] Legal Guardian

With whom does the child reside? _____

School's Name _____ Grade _____ Teacher _____

Teacher's Email _____ Teacher's Phone _____

Primary language spoken in home _____

Please provide the best two phone numbers and check the box if we may leave messages regarding your child's therapy at this number.

[ ] Mother's Cell Phone _____ [ ] Work Phone _____

[ ] Father's Cell Phone _____ [ ] Work Phone _____

[ ] Home Phone _____ [ ] Other Phone _____

Please provide 2 emergency contacts.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PERSONAL INFORMATION (continued)

Please list any known allergies (medication, food, etc.). _____

_____

Other persons living in the home:

Name	Age	Male/Female	Relationship	Medical Problems

PRIMARY INSURANCE INFORMATION

Does your child have Medicaid _____ and/or Private Insurance? _____

(Please provide copy of Insurance card.)

GENERAL MEDICAL INFORMATION

Pediatrician/PCP _____ Clinic _____

Other Health Care Professionals involved (ENT, Counselors, Surgeons, etc.) and Name of Office

_____

_____

Medical Diagnosis (reason for referral to therapy) _____

Who referred you here? _____

Parent's concerns leading to therapy _____

Parents' goals for therapy _____

When was the problem first noticed? _____

Has your child been seen by anyone else for these concerns? If so, when and where?

Location	Date

PRENATAL HISTORY

[ ] Foster or adoptive parent with limited knowledge of birth history [ ] Biological parent(s)

Full term pregnancy? [ ] Yes [ ] No # of Weeks _____ Weight and Length _____

[ ] Vaginal delivery [ ] Planned C-section [ ] Emergency C-Section

Complications during pregnancy/delivery _____

_____

Suction or ventilator required for child? [ ] Yes [ ] No Details _____

Length of time in hospital for child _____ For mother _____

Did the child go to the NICU? If so, why? _____

_____

Please indicate if any of the following occurred during the mother's pregnancy:

			Description
Infections/Illnesses	[ ] Yes	[ ] No	_____
Medications	[ ] Yes	[ ] No	_____
Drug/Alcohol Exposure	[ ] Yes	[ ] No	_____
Other Complications	[ ] Yes	[ ] No	_____

MEDICAL HISTORY

Please check all that apply/applied to your child as an infant:

[ ] Fussy [ ] Calm [ ] Good sleep patterns [ ] Enjoyed being held
[ ] Floppy [ ] Spit up often [ ] Poor sleep patterns [ ] Resisted being held
[ ] Irritable [ ] Active [ ] Alert [ ] Poor/picky eater
[ ] Quiet [ ] Babbled [ ] An easy baby

Comments _____

Family history (please specify family member's relationship to patient on line provided).

[ ] Developmental delays _____
[ ] Autism _____
[ ] Mental retardation _____
[ ] Mental illness _____
[ ] Other genetic disorders _____

Please check if your child has a history of:

[ ] Ear Infections [ ] Allergies [ ] Surgery [ ] PE Tubes
[ ] Trach [ ] Seizures [ ] Reflux [ ] Feeding/Swallowing Deficits
[ ] Meningitis [ ] Vision Deficits [ ] Behavioral Problems
[ ] Chronic Colds [ ] Hospitalizations [ ] Hearing Deficits
[ ] Asthma [ ] Heart Problems [ ] Congenital Defects
[ ] Other (If yes, please explain)

Please list any medications that your child is currently taking.

Medication	Reason for taking	Approx. Date Started

Please check if your child uses any of the following assistive devices

[ ] Glasses [ ] Hearing Aid [ ] Walker
[ ] Orthotics [ ] Shoe Inserts [ ] Wheelchair
[ ] Other _____

MOTOR DEVELOPMENT HISTORY

Please check either typical or unable for any of the following and explain your concerns.

Action	Typical	Unable	Concerns
Rolled over			
Sat independently			
Stood independently			
Crawled independently			
Walked (no support)			
Climbed steps			
Ran with control			
Jumped			
Skipped			
Rode a bicycle			
Ate table foods			
Drank from a cup			
Fed self with spoon			
Dressed independently			
Toilet trained (day)			
Toilet trained (night)			
Wrote name			
Cut with scissors			

ACTIVITIES OF DAILY LIVING/FUNCTIONAL INDEPENDENCE MEASURE (FIM)

KEY 7= Complete Independence 6= Modified Independence 5= Set Up 4= Min Assist
3=Mod Assist 2= Max Assist 1= Total Assist

ADL	FIM Score	ADL	FIM Score
Upper body dressing		Bathing	
Lower body dressing		Brushing teeth	
Buttons		Brushing hair	
Snaps		Washing face	
Zippers		Washing hands	
Tying shoes		Toileting	

Comments _____

SPEECH AND LANGUAGE DEVELOPMENT

Last hearing screening _____ Results _____

Describe, in your own words, what problem your child is having with speech, language, and/or hearing. _____

_____

_____

When did your child's speech and language skills first become an area of concern? _____

_____

Have any of your child's relatives had speech and language difficulties? If so, who and what type of difficulty did they have? _____

_____

How does your child typically communicate?

[ ] Gestures & pointing [ ] Short phrases [ ] Sentences

[ ] Screaming [ ] Single words [ ] Other _____

[ ] Augmentative device

How much of what your child says do you understand? _____ % intelligible

How much of what your child says do other people understand? _____ % intelligible

Does your child receive any speech therapy services in school? [ ] Yes [ ] No

If yes, what is the focus of their speech therapy? _____

_____

SOCIAL AND SENSORY DEVELOPMENT

Please check any of the following that apply to your child

[ ] Plays appropriately with toys
[ ] Has difficulty concentrating
[ ] Has behavior problems
[ ] Appears awkward or clumsy
[ ] Interacts with peers appropriately
[ ] Takes turns
[ ] Seems lazy/lethargic
[ ] Has difficulty sitting still
[ ] Shies away from new activities
[ ] Likes to crash into things
[ ] Reacts to loud noises/bright lights
[ ] Avoids eye contact
[ ] Prefers certain types of clothing
[ ] Uses a pacifier (now or ever)
[ ] Interacts with adults appropriately
[ ] Seems impulsive
[ ] Gets easily frustrated
[ ] Uses an augmentative communication device
[ ] Keeps up with peers in classroom academically
[ ] Sensory issues
[ ] Has sensitivities to textures (clothing, tags, bathing, foods)
[ ] Engages in odd behaviors; give example _____

_____

[ ] Dislikes changes/transitions; explain _____

_____

[ ] Has inappropriate fears/avoidances; explain _____

_____

Comments _____

Does your child limit the number of foods he/she will eat? [ ] Yes [ ] No

If yes, what foods does your child typically eat? _____

_____

Specific feeding problems/nutritional concerns? _____

_____

OTHER INFORMATION

Concerns and other helpful information _____

_____

_____

_____

What is your favorite thing about your child? _____

_____

_____

_____

Person completing form _____ Relationship to child _____