BIG BLUE CANOPY
PEDIATRIC GYM & THERAPY SERVICES

DEVELOPMENTAL AND MEDICAL HISTORY

Child's name : _____ Date of Birth : _____

Name of person completing this form : _____

Relationship to child : _____

Is your child adopted ? Yes No

Birth History

Child was born: full-term or premature;If premature, how many weeks ? _____

Delivery: vaginal with forceps C-section

Were there any complications ? _____

Was your child placed in the Newborn Intensive Care Unit ? _____ If so, how long ? _____

Please describe any other medical problems or complications at birth.

_____

Developmental History

Please indicate at what age your child achieved the following milestones:
*Mark N/A for those which your child has not achieved yet

Rolled over	_____	Babbled	_____	Sat alone	_____
Said first word	_____	Crawled	_____	Drank from a cup	_____
Pulled to stand	_____	Used spoon	_____	Stood alone	_____
Toilet trained	_____	Walked alone	_____	Dressed self	_____

Current limitations : _____

Comments:

_____

Medical History

Current diagnosis: _____

Hospitalizations: No Yes; If yes, please describe _____

_____

Surgeries: No Yes; If yes, please list _____

Previous psychological evaluation ? No Yes; If yes, please describe _____

_____

Current physician(s): _____ Medications: _____

Special equipment your child uses: Splints Braces Adaptive utensils Other _____

Any feeding problems or nutritional concerns ? _____

Please check all that apply to your child:

Tracheostomy	Allergies (list below)	Hearing aids	Wears glasses
C-Line	Latex Sensitivity	Hearing difficulty	Vision problem
G-tube	Seizures		

Comments:

_____

Educational Information

School/Educational program currently attending: _____

Present grade level: _____

Special services received in school: OT PT Speech

Does your child receive any of the following?

Special Education Behavior Intervention Other special service

Does your child's teacher have concerns with your child's development in any of the following areas:

Motor skills Social abilities Self-help skills Learning abilities

Comments:

_____

Social/Emotional Development

Does your child interact well with others ? Yes No

Does your child have any trouble making friends ? Yes No

Fears, Coping behaviors : _____

Does your child have difficulty calming himself/herself when upset ? Yes No

Additional comments:

_____

Behavior

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

Cries often	Dislikes hair brushing	Frequent temper	Tantrums
Dislikes tooth brushing	Anxious	Avoids touch from others	
Trouble following directions	Dislikes playground equipment	Trouble with changes in routine	
Seems to be "on the go" Clumsy	Rocks self	Weak muscles	
Sensitive to light	Picky eater	Sensitive to sound Mouths objects	
Poor attention span			

Other Professionals Working With Child

Optometrist/Ophthalmologist	ENT-Otolaryngologists	Neurologist	Physiatrist
Orthotist/Prosthetist	Orthopedic Physician	Care Coordinator/Service Coordinator	

Other :

_____

Has your child received occupational therapy, physical therapy, or speech therapy before ? Yes No

If yes, please indicate which services and for how long : _____

Family Goals with Therapy

Childs strengths: _____

Parent Concerns: _____

Child's other interests/hobbies: _____

Goals for Therapy: _____

Thank you for taking the time to fill out this questionnaire.

Signature of Parent/ Legal Guardian: _____ Date _____

(By typing your name above you agree that your typed signature can be used as your actual signature.)

Relationship to the Patient _____