Allied Rehab
Speech, Occupational & Physical Therapy

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PEDIATRIC THERAPY HISTORY FORM

Name _____ Date of birth _____

What is your child's primary language? _____

What other languages are spoken at home? _____

Child' School: _____ Current Grade: _____

Does your child have an IEP (Individualized Education Plan)/ receive special education services at school? ☐ Yes ☐ No

If Yes, we will need a current copy of your child's IEP. Please bring a physical or electronic copy to us each time your child receives a new IEP

PLEASE FILL OUT THE SECTION THAT IS RELEVANT TO YOUR VISIT TODAY

SPEECH-LANGUAGE

What are your concerns regarding your child's speech?

- ☐ Articulation (ex: pronouncing words incorrectly)
- ☐ Language
  - ☐ Not saying enough words?
  - ☐ Not following directions/ understanding language?
  - ☐ Not speaking in full sentences?
  - ☐ Stuttering (ex: repeating sounds/ words)
  - ☐ Voice (ex: hoarse, raspy, breathy voice quality)
  - ☐ Swallowing/ Feeding

Other: _____

PHYSICAL THERAPY

What are your concerns regarding your child's physical development?

Difficulty with:

- ☐ Rolling
- ☐ Sitting
- ☐ Crawling
- ☐ Walking
- ☐ Balance/ Falling
- ☐ Coordination
- ☐ Torticollis/ Head Tilt
- ☐ Head Shape Concerns
- ☐ Pain/ where? _____

Other: _____

OCCUPATIONAL THERAPY

What are your concerns regarding your child's skills or behavior?

- ☐ Fine Motor (difficulty grasping writing utensils, feeding utensils, small objects)
- ☐ Visual Motor (pre-writing skills, puzzles, blocks, scissor skills)
- ☐ Handwriting
- ☐ Working fasteners (buttons, snaps, zippers, tying shoes)
- ☐ Self-Care skills (brushing hair, toileting, brushing teeth, dressing themselves/ putting on shoes)
- ☐ Sensory Processing (sensitivity to clothing, messy hands, cutting nails, loud noises, crowds, bright lights, movement seeking)
- ☐ Picky Eating
- ☐ Behavior (frequent meltdowns, difficulty with transitions, low frustration tolerance)

Other: _____