Aspen Center
planting roots for development

CLIENT BIRTH HISTORY

Name: _____ DOB: _____ Pediatrician:_____

1. Did you have a normal pregnancy? □ Yes □ No Length of pregnancy _____

2. Medications used during pregnancy:

3. Describe your child's delivery and birth:
□ Typical □ Spontaneous □ Induced
□ Cesarean □ Breech □ Unusually Long Labor
Please list any complications:

4. Duration of labor: _____

5. Medications used during labor:

6. What was your child's birth weight? _____

7. What was your child's condition at birth?
□ typical □ birth injury/defect □ jaundiced □ breathing problem □ low birth weight
□ other _____
Notes:

8. Does your child have a history of any of the following? (Check all that apply)

____ Drooling	____Chronic Ear Infections	____ Allergies
____ Asthma	____ Hearing Loss	____ Ear Tubes
____ Surgery	____ Reflux	____ Seizures
____ Hospitalization	____ Head Injury	____ Intubation/Ventilator
____ Serious Accidents	____ Chronic Severe Illness	
____ High/Prolonged Fevers		

9. Has your child ever been hospitalized? Why? How Long? Any long-term effects?

10. Has your child had a formal vision evaluation? Is so what were the results?

11. List any medication(s) your child is currently taking.

DEVELOPMENTAL HISTORY

12. Please tell the approximate age your child achieved the following developmental milestones:

____ Sat Alone	____ Crawling
____ Babbled	____ Said First Words
____ Put Two Words Together	____ Spoke In Short Sentences
____ Walked	____ Toilet Trained

13. Indicate any concerns you have for your child in the following area(s):

____ Articulation	____ Auditory Processing	____ Expressive Language
____ Reversals or Letters	____ Receptive Language	____ Social Skills
____ Reading Fluency	____ Slow Working	____ Poor Memory
____ Sensory	____ Attention/Concentration	____ Loses Place/Skips Lines
____ Motivation/Behavior	____ Over-Active	____ Feeding
____ Aggression	____ Anxiety	____ Rigidity

14. When did you first notice the problem(s) you indicated above?

15. Does your child receive any services at school (IEP or 504 plan) or outside help? □Yes □No
List all:

SPEECH

16. Are languages other than English spoken in the home? □ Yes □ No

If yes, please list _____

17. Does anyone in your family history have a speech, language, hearing or learning problem that you are aware of? □ Yes □ No If yes, please describe:

18. Has your child ever had a hearing evaluation? □ Yes □ No If yes, list dates and specific results (mild to moderate hearing loss, which ear, etc.):

19.Your child currently communicates using...

❑ body language (pointing, pulling) ❑ sounds (vowels, grunting)

❑ words (shoe, doggy, up) ❑ 2 to 4-word sentences

❑ sentences longer than four words ❑ other _____

20. Does your child...

❑ repeat sounds, words or phrases over and over?

❑ understand what you are saying?

❑ retrieve/point to common objects upon request (ball, cup, shoe)?

❑ follow simple directions ("Shut the door" or "Get your shoes")?

❑ respond correctly to yes/no questions?

❑ respond correctly to who/what/where/when/why questions?

21. My Child's speech is understood by: (Check all that apply)

a. Me ❑ all the time ❑ usually ❑ sometimes ❑ rarely

b. Household Family Members ❑ all the time ❑ usually ❑ sometimes ❑ rarely

c. Familiar People ❑ all the time ❑ usually ❑ sometimes ❑ rarely

d. Unfamiliar People ❑ all the time ❑ usually ❑ sometimes ❑ rarely

22. Does your child...

❑ choke on food or liquids?

❑ currently put toys/objects in his/her mouth?

❑ brush his/her own teeth?

❑ allow his/her teeth to be brushed?

23. Does your child have a history of feeding problems? If yes, check all that apply.

□ choking □ difficulty biting □ overstuffing mouth

□ poor nursing □ difficulty chewing □ difficulty swallowing

23. Is your child a messy or picky eater? □ Yes □ No

Please list favorite foods:

_____

Please list food sensitivities:

_____

SENSORY AND MOTOR

24. What is your child's sleep routine? What do they/you do before bed? What time do they go to bed at night? Uninterrupted sleep? How many hours of sleep do they get at night? What time do they wake up? Do they take a nap? If so, when and for how long?

25. Does (or did) your child have any difficulty walking, running, sitting or with any other large motor skills? □ Yes □ No If yes, please describe:

26. Does (or did) your child tippy-toe walk? □ Yes □ No

27. Is (or was) your child clumsy or does he/she fall easily? □ Yes □ No

28. Does (or did) your child have low body tone? □ Yes □ No

29. Does (or did) your child have difficulty with fine motor skills such as stacking, cutting and handwriting? □ Yes □ No If yes, please describe:

30. Is (or was) your child sensitive to certain textures of food or clothing? □ Yes □ No If yes, please describe:

31. Does your child dislike having substances on his/her hands such as glue or dirt? □ Yes □ No

32. Is your child oversensitive to being touched/dislikes being touched? □ Yes □ No If yes, please describe:

33. Check all that apply regarding your child, if any.

□ dislikes washing his/her face or hair □ does not demonstrate caution
□ dislikes haircuts □ puts things in his/her mouth besides food
□ chews on his/her clothes □ spends too little time or too much time brushing teeth

SOCIAL/EMOTIONAL AND OTHER BEHAVIORS

34. Does your child typically display any of the following behaviors? (Check all that apply.)

□ Reduced or lack of interaction with others
□ Tantrums
□ Passive in interactions
□ Very active
□ Underactive
□ Inattentive
□ Refuses to perform tasks
□ Fearful of specific source
□ Fearful of general sources
□ Rigidity
□ Difficulty staying on task
□ Difficulty finishing tasks
□ Sensitive
□ Angry/Acting out behavior
□ Frustrated
□ Shy
□ Difficulty getting along with peers
□ Difficulty getting along with siblings
□ Difficulty getting along with adults

ACTIVITIES OF DAILY LIVING (ADLs)/ SELF CARE

35. **Dressing:** How does your child dress themselves?
□ Independently
□ With reminders
□ With some physical assistance
□ Caregiver does the dressing

36. **Eating:** How does your child eat?
□ Using spoon
□ Using fork
□ Using fingers only
□ Alone but at a different time than other family members
□ With family at mealtimes
□ Where does your child eat? (example: at family table)

37. Drinking: What does your child drink from?
□ Bottle
□ Sippy Cup
□ Straw Cup
□ Open Cup

OTHER INFORMATION

38. Please list any known allergies (i.e. food, latex, bees, etc.) **(REQUIRED)**

39. Who does your child live with? (Check all that apply.)

□ Both parents □ Grandparents □ Mother only

□ Foster parents □ Father only □ Parent + Stepparent

40. Has your child been evaluated or treated by any other professional? (Check all that apply.)

□ Speech-Language Pathologist □ Educator/teacher

□ Occupational Therapist (OT) □ Neurologist

□ Physical Therapist (PT) □ Physician

□ Developmental Pediatrician (specialist) □ Geneticist

□ Psychologist/Psychiatrist □ Other_____

If yes, please indicate where services were/are provided, how frequently, for how long and the outcome of the therapy.

41. Does your child have a diagnosis (for example: ADHD, Autism, Visual Impairments) from any of the above professionals? □ Yes □ No

If yes, please list date, professional, and diagnosis for each.

42. What other concerns do you have about your child?

43. What do you consider to be your child's greatest strengths?

44. What do you hope to gain from this evaluation?