LANGSTON
Pediatric Therapy
HELPING SMALL HANDS DO BIG THINGS

Background History Form

Child's Name _____ **Birth Date** _____**Today's Date** _____

Age_____ Parents/Guardians Full Names_____

Siblings and Ages_____

Primary Language Spoken In the Home_____ Other Languages_____

Referred by _____

Person Completing this Form _____Relationship to Child_____

Birth Information (check all those that apply)

Diabetes □ Measles □ Toxemia □ Premature Labor □ Strep □ Respiratory □ Other □

Complications During Labor/Delivery

Cesarean Section _____ Emergency? Y N Forceps_____ Vacuum_____ Other_____

Medications Given During Delivery _____

Describe Child's Condition At/Or Immediately After Birth:

Premature_____ (If Yes) Gestational Age_____ Apgars_____NICU_____ (If Yes) How Long?_____

Ventilator _____(If Yes) How Long?_____ Jaundice _____ Heart Problems _____Poor suck _____

Small For Gestational Age _____Large for Gestational Age _____

Birth Weight_____ Birth Length_____

Known Diagnosis _____

Other Medical Complications _____

Child's Medical History:

Measles □ Mumps □ Pneumonia □ Chicken Pox □ Bronchitis □ Reflux □ Allergies □ Head Injuries □

Tonsillitis □ Tongue Tied □ Other □ _____

Ear Infections _____ Frequency _____ Last Ear Infection _____

Treatment Method _____Tubes _____; When _____

List Any Hospitalizations:

Dates (from____ to____)	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Any Surgeries Performed:

Ear Tubes _____ Still in place? _____ Tonsils_____ Adenoids _____

Other: _____

_____

Test Performed:

MRI____ CT Scan_____ Genetic Testing _____ X-rays _____ Other _____

Please list current Medications: _____

_____

_____

Has Your Child Had Any Seizures? □ YES □ NO If Yes, please describe and indicate frequency _____

_____

Please list any allergies: _____

_____

Child's Developmental History

Developmental Milestones:

Please list the approximate age the child accomplished the following:

Lift Head While on Tummy_____ Roll Over _____ Sat Without Support _____Crawled _____

Stood Alone_____ Walked alone _____ Dress/Undress Self_____ Button/Zip Clothes_____

Started Solid Foods _____ Held Cup/Used Fork _____ Drank from Sippy Cup _____ Open Cup _____

Dry During Day _____ Dry At Night _____ Gain Bowel Control_____ Hand Preference: L R

Does Your Child Have Any Bowel Or Bladder Difficulties? Please Describe: _____

_____

Speech:

Please list the approximate age the child accomplished the following:

Babble (dada, baba, etc) _____ Said First Words _____ Combined Words _____

Does your child respond when his/her name is called? Y N Follow simple directions? Y N

Approximately how many words does your child have? _____

How does your child tell you what he/she wants? _____

Does your child ask and answer questions? _____

Check any areas of concern regarding Speech and Language:

Length of statements your child uses □ Ability to produce sounds correctly □

Ability to find the right word (i.e. I want that, uh, thing that, uh, goes around) □

Fluency of Speech (e.g. I-I-I will go to-to-to-to school now.) □

Quality of Voice (e.g., nasal, hoarse, pitch) □ Ability to sustain attention □ Ability to stay on topic □

Ability to initiate a topic □ Ability to establish peer relationships □ Ability to follow directions □

When did you first notice difficulties with your child's speech and language? _____

Is there any family history of speech and language difficulties? Y N Please describe: _____

_____

Feeding:

Does your child have any feeding difficulties with the following:

Poor suck: _____ Difficulty Swallowing _____ Difficulty Chewing _____ Gage/Choke Often _____

Finger Feeding _____ Spoon Use _____ Required a Feeding Tube _____ Reflux/Vomiting _____

List any other Feeding concern: _____

Is your child a picky eater? Y N Does your child dislike particular textures of food Y N

What is your child's favorite food _____ Least favorite food _____

Hearing/Vision

Has your child ever had a vision test? Y N If Yes, date last performed/results_____

_____

Does your child wear glasses Y N

Has your child ever had a hearing test? Y N If Yes, date last performed/results_____

_____

Does your child have a hearing aide? Y N If Yes, please indicate □Left □Right

Sensory History:

Does your child's hands, feet and/or tummy seem overly sensitive to touch Y N

Does your child seem distractible or overactive Y N If Yes, please describe _____

_____

Does your child tolerate toothbrushing? Y N

Educational History:

What school does your child attend? _____ Current grade level_____

How often does he/she attend school? _____days per week _____ hours per day

What are your child's strengths in school? _____

What areas at school are most difficulty for your child? _____

Additional Information:

Please list any behavioral issues: _____

_____

Please explain why you want this evaluation done: _____

_____

Has your child had any previous evaluation/therapy? Y N

If yes, please provide dates, facility where performed, type of therapy and reason(s) _____

_____

_____

Please list any pertinent family medical history _____

_____

_____

Is there any else that you would like us to know about your child? _____

_____

_____

Thank you for taking the time to complete this form.

The information you provided is valuable in assessing your child's skills.