ROOTS TO SHOOTS
BCH Pediatric Therapy Clinic

PATIENT INFORMATION

Child's Name: _____

Current Diagnosis: _____

School Attendance History:_____Grade:_____

Reason for Referral:_____

Parent/Guardian #1 Name: _____

Relationship to Child: _____Custody Status:_____

Email: _____

Emergency Contact:_____Relationship:_____Phone:_____

Parent/Guardian #2 Name: _____Occupation: _____

Relationship to Child: _____Custody Status:_____

Email: _____

Who does the child reside with? _____

List any medical precautions/allergies/medications:

Does your child ever complain of pain? If yes, in what area? Please describe:

Is your child receiving any other services? (Occupational Therapy, Physical Therapy, Speech Therapy, Special Education, Early Intervention)

Please list any significant prenatal or birth history:

- ☐ Premature (Gestation: _____weeks)
- ☐ Preeclampsia
- ☐ Full Term
- ☐ Gestational Diabetes
- ☐ Low Birth Weight (_____lbs)
- ☐ Breast Fed
- ☐ Breech Birth
- ☐ Poor Suction/Latch
- ☐ C-section Birth (Planned)
- ☐ Bottle Fed
- ☐ Emergency C-section
- ☐ Multiple Ultrasounds
- ☐ Vaginal Birth
- ☐ Oxygen at Birth
- ☐ Forceps Delivery
- ☐ NICU Stay (Duration:_____)
- ☐ Vacuum Delivery
- ☐ Other: _____

What (if any) special equipment does your child use?

- ☐ Wheelchair
- ☐ Braces
- ☐ Walker
- ☐ Crutches
- ☐ Eye Glasses
- ☐ Hearing Aids
- ☐ Communication Device
- ☐ Other:

What are your primary areas of concern/What are your goals for therapy?

MEDICAL HISTORY

Please list any significant illness, hospitalizations, etc.:

Please check all that apply to your child:

- ☐ Chronic Ear Infections
- ☐ Lyme Disease
- ☐ Tubes
- ☐ Abnormal Muscle Tone
- ☐ Tonsils/Adenoid Surgery
- ☐ Torticollis
- ☐ Reflux
- ☐ Frequent Antibiotic Use
- ☐ Surgeries (list above)
- ☐ Frequent Fevers
- ☐ Poor Weight Gain
- ☐ Compromised Immune System
- ☐ Colic
- ☐ Abnormal Lab Results
- ☐ Poor Sleep
- ☐ Cardiac Issues
- ☐ Asthma
- ☐ Other:_____

DEVELOPMENTAL HISTORY

Please list the approximate age your child was able to do the following (to the best of your ability):

- ☐ Lift head while on tummy_____
- ☐ Started solid food _____
- ☐ Roll over_____
- ☐ Held cup _____
- ☐ Sat without support _____
- ☐ Toilet trained _____
- ☐ Crawled _____
- ☐ Fed self _____
- ☐ Stood alone _____
- ☐ First single words_____
- ☐ Walked alone _____
- ☐ Put words together_____
- ☐ Ran alone _____
- ☐ Dressed/Undressed self_____

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.)

Please list any concerns with feeding/eating or allergies.

Please check all of the following that describe your child:

- ☐ Was placed on belly as an infant
- ☐ Was not placed on belly as an infant
- ☐ Enjoyed belly time as an infant
- ☐ Did not tolerate being placed on belly
- ☐ Met all motor milestones
- ☐ Was late to: _____
- ☐ Is athletic/plays sports
- ☐ Was/is developmentally delayed
- ☐ Is good negotiating playground equipment
- ☐ Is clumsy
- ☐ Is good with hands (fine motor skills)
- ☐ Avoids climbing, swinging, sliding
- ☐ Handles public places with ease
- ☐ Gets overwhelmed in public places

SPEECH/LANGUAGE DEVELOPMENT

What is your child's primary mode of communication? (i.e. gestures, singing, single words, short phrases, sentences, augmentative device, picture exchange, etc.)

Please give an estimate of how many words are in your child's vocabulary:

Receptive (words understood):_____ Expressive (words spoken):_____

How much of your child's speech do you understand?

10% or less ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100% ☐

Are there any sounds your child has difficulty with? Please list:

Does your child demonstrate frustration when not understood? ☐ Y / N ☐

Is your child able to follow 1-2 step directions? ☐ Y / N ☐

Has your child's hearing been checked recently? ☐ Y / N ☐

Results:_____

BEHAVIOR/SOCIAL HISTORY

Please check all that apply to your child:

- ☐ Is social and engaging
- ☐ Is aggressive
- ☐ Makes good eye contact with others
- ☐ Is oppositional
- ☐ Is well behaved
- ☐ Does not like new places/people
- ☐ Pays attention
- ☐ Does not like crowds
- ☐ Listens well
- ☐ Has difficulty with transitions
- ☐ Plays well with other children
- ☐ Prefers to play alone
- ☐ Does well with change
- ☐ Has difficulty listening/paying attention
- ☐ Understands safety
- ☐ Poor coping skills
- ☐ Takes turn with peers
- ☐ Unable to self-calm
- ☐ Maintains topic
- ☐ Quickly escalates with apparent cause

Please list any behavioral or social concerns:

What are some of your child's favorite toys/interests?

EVALUATION & THERAPY SERVICES

Please list any previous therapy evaluations completed with recommendations provided:

Please list any previous psychological/neuropsychological/psych-educational evaluations completed with recommendations provided:

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give permission to Roots to Shoots Pediatric Therapy to discuss, release, or obtain information relative to my child's therapy from the following professionals (i.e.pediatrician, teacher(s), psychologist, developmental optometrist, vision specialists, speech and language therapist(s), physical therapist(s), occupational therapist(s), etc.)

(1) Pediatrician Name: _____

Address: _____

Phone: _____

(2) Teacher Name: _____

Address: _____

Phone: _____

(3) Other Name: _____

Address: _____

Phone: _____

(4) Other Name: _____

Address: _____

Phone: _____