ALPHA REHABILITATION
CHILD'S HEALTH INFORMATION

Please list all diagnoses your child has been given:________________________________
____
____

At how many weeks gestation was your child born? (I.e., full-term, 36 weeks, etc.):
____

What was your child's birth weight?____

Please identify anything significant about the pregnancy or delivery of your child:
____
____
____

Please identify at what age your child…

Rolled: _____________________________________

Crawled: ____________________________________

Walked: _____________________________________

Spoke first word: _____________________________

Does your child have or has your child ever had an IEP or IFSP: If yes, please list services provided:____
____

Childhood Hospitalizations and/or Surgeries:

Age:_______ Reason:____

Age:_______ Reason:____

Age:_______ Reason:____

Allergies:____
____

Past Medications (please list ages):____
____
____

Current Medications:____
____
____

Therapy and/or other specialists who have seen the child:

Past (Please list ages):____
____

Current:____
____
____

On a scale of 1 to 4, how well does the child function in the following areas? (Circle one)

1= Completely dependent on others. Needs lots of help or cues
4= Completely independent. No difficulties in this area.

Dressing Upper Body	1	2	3	4	Not applicable
Dressing Lower Body	1	2	3	4	Not applicable
Toileting	1	2	3	4	Not applicable
Eating (breast or bottle)	1	2	3	4	Not applicable
Eating (soft foods off spoon)	1	2	3	4	Not applicable
Eating (with fingers)	1	2	3	4	Not applicable
Eating (with utensils)	1	2	3	4	Not applicable
Playing with familiar peers	1	2	3	4	Not applicable
Playing with unfamiliar peers	1	2	3	4	Not applicable
Handwriting	1	2	3	4	Not applicable
Frustration Tolerance	1	2	3	4	Not applicable
Sleeping routine	1	2	3	4	Not applicable
Grooming (hair)	1	2	3	4	Not applicable
Grooming (bathing)	1	2	3	4	Not applicable
Grooming (teeth)	1	2	3	4	Not applicable
Maintaining attention to tasks	1	2	3	4	Not applicable
Entertaining self	1	2	3	4	Not applicable
Hand/Eye coordination	1	2	3	4	Not applicable
Balance	1	2	3	4	Not applicable
Following verbal directions	1	2	3	4	Not applicable
Safety awareness	1	2	3	4	Not applicable
Cutting with scissors	1	2	3	4	Not applicable
Reading	1	2	3	4	Not applicable
Social Skills	1	2	3	4	Not applicable
Walking	1	2	3	4	Not applicable
Sitting or standing balance	1	2	3	4	Not applicable
Positioning during play or daily routines	1	2	3	4	Not applicable
Crawling	1	2	3	4	Not applicable
Strength and Endurance	1	2	3	4	Not applicable

How does you child communicate (gestures, single words, short phrases, sentences). Please indicate approximate number of words spoken?

____
____
____
____
____

Are there or have there been any feeding problems with sucking, swallowing, drooling or and/or chewing? Please indicate type and quantity of diet consumed.

____
____
____
____

Please list your child's strengths:

____
____

Please list your child's weaknesses:

____
____

What are your goals for therapy?

____
____
____
____

Please let us know your child's favorite things:

Food:_________________________ Snack:_______________________________

Drink:________________________ Candy:_______________________________

Toy:_________________________ Game:_______________________________

Activity:_____________________ TV show/movie:_______________________

Other:____

Any other information you want to share with us: