523 Village Park Drive Powell, OH 43065 614.785.6551 www.sensorysolutionsohio.com

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CONFIDENTIAL PERSONAL HISTORY FOR CHILDREN AND YOUNG ADULTS

Today's Date: _____

Completed by: _____

Last Name: _____

Child's Name: _____

Address: _____

_____

Birthdate: _____

Age: _____

City, State, Zip: _____

Gender: _____

Ethnicity: _____

Email: _____

CONTACT INFORMATION

Mother's Name:_____

Father's Name:_____

Address: _____

Home phone:_____

Cell phone:_____

Emergency:_____
Name Relationship Phone

School:_____

Grade in School:_____

Teacher's Name:_____

Type of Classroom:_____

Child's Physician's or Health Care Providers (including Primary Care Physician):

Name:_____
Profession: _____
Phone:_____
Address:_____

Name:_____
Profession:_____
Phone:_____
Address:_____

Name:_____
Profession_____
Phone:_____
Address:_____

Date of Child's Last Medical Checkup:_____ Height:_____Weight:_____
Are there any medical precautions the therapist should be aware of when working with your child?

_____
_____
_____
_____

FAMILY MEMBERS – Detailed Information

	Age	Sex	Adopted	Occupation	Handedness
Father					
Stepfather					
Mother					
Stepmother					
Children					

Marital Status of Parents: ___Married ___Separated ___Divorced ___Other

Mother's Education ___Less than High School
___High School or GED
___College
___Post College (grad school)

Stepmother's Education ___Less than High School
___High School or GED
___College
___Post College (grad school)

Father's Education ___Less than High School
___High School or GED
___College
___Post College (grad school)

Stepfather's Education ___Less than High School
___High School or GED
___College
___Post College (grad school)

PERSONALITY PROFILE

What are your child's gifts / strengths?_____

_____

_____

_____

What do you enjoy most about your child and family?_____

_____

_____

_____

What are the presenting problems for your child? (All categories below may not apply.)

Academic:_____

_____

Activities of daily life (e.g. eating, dressing):_____

_____

Relationships:_____

_____

Sensory:_____

_____

Motor:_____

_____

Play:_____

_____

Other:_____

_____

What kind of interests and activities does your child have? (hobbies, sports, clubs)

Please list them in order of preference beginning with the favorite activity.

_____

_____

_____

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

____ADD
____ADHD
____Anxiety Disorder or Mood Disorder (specify): _____
____Autistic Spectrum Disorder
____Cognitive Delay
____Down Syndrome
____Dyslexia
____Emotional Disorder (specify): _____
____Fragile X Syndrome
____Learning Disabilities (specify if possible): _____
____Sensory Processing Disorder or Sensory Integration Dysfunction
____Tourette's Syndrome
____Other (specify): _____

Please note who provided the diagnosis and based on what criteria (i.e., test scores, comprehensive clinical evaluation, genetic study, etc.):_____

_____

_____

MEDICATIONS

List any medications your child has received **in the past:**

Medication:_____ Purpose:_____ When taken:_____
Medication:_____ Purpose:_____ When taken:_____
Medication: _____ Purpose:_____ When taken:_____
Medication:_____ Purpose:_____ When taken:_____
Medication:_____ Purpose:_____ When taken:_____

List any medications your child is **currently** taking, its purpose and frequency of dosage:

Medication:_____ Purpose:_____ When taken:_____
Medication:_____ Purpose:_____ When taken:_____
Medication:_____ Purpose:_____ When taken:_____
Medication:_____ Purpose:_____ When taken:_____
Medication:_____ Purpose:_____ When taken:_____

FAMILY ADAPTATION

How would you describe your child's general adjustment at home? ☐ Poor ☐ Fair ☐ Good ☐ Excellent
How does your child get along with each member of the family?

Father _____

_____

Mother _____

_____

Siblings_____

_____

Have there been any traumatic family events in the course of this child's development?

_____

_____

_____

Have there been any major moves? (city to city, country to country)

_____

_____

_____

_____

PREGNANCY (If child is adopted, skip to Adoption Section)

What kind of experience was the pregnancy for both mother and father?

Mother

_____

_____

Father

_____

_____

	Yes	No	Comments
Was it planned?	_____	_____	_____
Were there complications?	_____	_____	_____
shock	_____	_____	_____
severe stress	_____	_____	_____
loss of a loved one	_____	_____	_____
accident	_____	_____	_____
health problems, specify	_____	_____	_____
confinement to bed	_____	_____	_____
other	_____	_____	_____
Was the mother exposed to loud noises?	_____	_____	_____
Did mother smoke?	_____	_____	_____
Did mother consume alcohol?	_____	_____	_____
Did mother take any medication? specify	_____	_____	_____
Was mother physically active?	_____	_____	_____
Were any previous pregnancies complicated?	_____	_____	_____

LABOR AND DELIVERY

Describe your experience during labor and delivery _____

_____

		Comments
Length of labor?	Hrs _____	_____

Premature: specify Yes _____ No_____ _____

Forceps used Yes_____ No_____ _____

High forceps required Yes_____ No_____ _____

Suction Yes_____ No_____ _____

Delivery position (ex: breech) _____

Caesarean birth (reason) Yes_____ No_____ _____

Birth weight ____ lbs ____oz

APGAR ratings (if known) _____ _____ _____

Cried immediately Yes_____ No_____ _____

Required special treatment (i.e. required oxygen, had jaundice, etc.) Yes_____ No_____ _____

Birth injuries: specify Yes_____ No_____ _____

Did the newborn have immediate physical contact with the mother? Yes_____ No_____ _____

Was there a positive bonding experience between mother and newborn at birth? Yes_____ No_____ _____

Describe any separations from mother during first days of life_____

Did mother experience any post-partum depression? Yes_____ No_____ _____

ADOPTION

Describe the circumstances surrounding the adoption:

_____

_____

_____

More specifically:

Age when adopted:_____

Prior foster homes:_____

Physical appearance: _____

Response to new home: _____

_____

Is your child aware of his/her adoption? _____

INFANT & TODDLERHOOD

Going back to the **first two years** of the child's life, what type of baby was he/she? (feeding, sleeping, activity level)

_____

_____

_____

_____

	Yes	No	Comments
Breastfed			
Extended separation during first two years (over 3 days)			
Specific health problems during this period			
Thumb sucking / pacifier (until what age)			
Feeding problems			
Sleeping problems			
Colic or "fussy baby"			
Prefer certain positions as an infant (describe)			
Dislike lying on stomach			
Dislike lying on back			
Able to self soothe			
On a regular schedule			\
Enjoy bouncing			
Become calmed by car rides or infant swings			
Become nauseated by car rides or infant swings			
Crawled (at what age)			
Toe walker (until what age)			
Go through "terrible twos"			

Describe your child's toddler stage: _____

_____

_____

CHILDHOOD ILLNESS / PROBLEMS

	Age	**Comments / Deficits**

_____ Ear infections _____ _____

_____ Tubes in ears _____ _____

_____ Respiratory problems _____ _____

_____ High fever _____ _____

_____ Meningitis _____ _____

_____ Adenoid problems _____ _____

_____ Frequent colds _____ _____

_____ Strep throat _____ _____

_____ Allergies _____ If yes, please specify:_____

_____

Check the items below which have been a problem and provide details:

Asthma _____ _____

Bronchitis _____ _____

Skin problems _____ _____

Gastro-Intestinal problems_____ _____

Seizures _____ _____

Epilepsy _____ _____

Nightmares _____ _____

Sleep _____ _____

Bedwetting _____ _____

Nail Biting _____ _____

Broken limbs _____ _____

Other _____ _____

Has he/she ever been hospitalized? Yes ____ No____
If yes, list reasons: _____

_____

Has he/she ever had a serious accident/injury? Yes ____ No____
If yes, list accidents:_____

_____

Are there any other medical illnesses or conditions which have been diagnosed?

_____

_____

Is your child in good general health at the present time? _____

DEVELOPMENTAL MILESTONES

(Give approximate ages if remembered, or comment on anything unusual)

Rolling over_____ Walk_____ Say words_____

Sit alone_____ Chew solid food _____ Say sentences_____

Crawl_____ Drink from a cup_____

Was crawling phase brief? Yes☐ No☐ Absent? Yes☐ No☐

Did child use a walker (rolling plastic seat)? Yes___ No___ If yes, how often?_____

Experience hesitancy or delays in learning to go down stairs? Yes☐ No☐

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision?_____

_____

Are there any current problems of which you are aware?_____

_____

When was the last time his/her eyesight was tested?_____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (operations, infections, tubes)

_____

_____

Ear infections? Seldom☐ Sometimes☐ Often☐

Mild☐ Moderate☐ Severe☐

Are there any current hearing problems of which you are aware?

_____

_____

Speech and Language Development

How would you describe your child's speech and language development?
Normal _____ Delayed _____
How does your child primarily communicate wants and needs?
Vocalizing _____ Gestures_____ Pointing/Leading _____
Provide the approximate age at which your child began to:

Use single words _____ Combine words _____
If using single words or word combinations, does your child have a vocabulary consisting of 5-10 words _____
10-20 words _____ 20-50 words _____ 50+ words _____
Do you or others have difficulty understanding what the child says?
Yes _____ No _____
Did your child have words and/or phrases and then show regression in speech-language skills?
Please Describe: _____

_____

_____

_____

_____

SENSORY and MOTOR DEVELOPMENT

Please check any that apply:

_____ My child seems to be overly sensitive to sensory experiences more so than most people:

☐ Auditory ☐ Tactile ☐ Visual ☐ Movement ☐ Taste ☐ Smell

_____ My child doesn't seem to react to sensory experiences as readily as most people:

☐ Auditory ☐ actile ☐ Visual ☐ Movement ☐ Taste ☐ Smell

_____ My child actively seeks out sensory experiences more so than most people:

☐ Auditory ☐ Tactile ☐ Visual ☐ Movement ☐ Taste ☐ Smell

_____ My child has difficulty differentiating sensory experiences.
(ex: confuse sounds, can't find objects in drawer or bag without looking, bumps into things)

Describe:_____

_____

_____

_____ My child has trouble learning new movements.

_____ My child tends to be clumsy and has balance and coordination problems.

ACTIVITIES OF DAILY LIVING

EATING

Does your child finger feed? ☐ Yes ☐ No Comments:_____

Does your child use:
☐ Fork ☐ Spoon ☐ Sippy Cup ☐ Regular Cup Other:_____

DRESSING

Does your child assist with dressing? ☐ Yes ☐ No Comments:_____

Does your child put on/ take off:

☐ Socks ☐ Shoes ☐ ants/Shorts ☐ Shirts ☐ Coats

Does y our child manipulate fasteners:

☐ Zippers ☐ Snaps ☐ Velcro ☐ Buttons

TOILETING

Is your child potty trained? ☐ Yes ☐ No Comments:_____

Is your child able to manage clothes for toileting? ☐ Yes ☐ No Comments:_____

Is your child able to wash their hands independently after toileting? ☐ Yes ☐ No Comments:_____

PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENT
Please attach relevant reports

	ASSESSMENTS			**TREATMENTS**		
	Yes	No	Place / Date	Yes	No	Place / Date
Medical	____	____	_____	____	____	_____
Audiological	____	____	_____	____	____	_____
Speech	____	____	_____	____	____	_____
Educational	____	____	_____	____	____	_____
Psychological	____	____	_____	____	____	_____
Occ. Therapy	____	____	_____	____	____	_____
Other	____	____	_____	____	____	_____

Comments: _____

_____

Have there been any specific events or traumas linked with the onset of your child's difficulties?

_____

_____

_____

Is your marital situation stable and positive at this time? _____

_____

_____

_____

What, if any, stresses are affecting your family at this time?

Which language(s) is spoken at home? _____

Are there other individuals or family members living at home? (other than immediate family)

EDUCATION

How did your child adapt to the first day(s) at school or pre-school:

Mostly positive ☐ Mixed ☐ Mostly negative ☐

How old was he/she? ☐ How much time did he/she attend per week? ☐

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment _____

Pre-school/Daycare _____

Primary (K – Gr. 3) _____

Junior (Gr. 4-6) _____

Intermediate (Gr. 7-8) _____

High School _____

Has there been remedial help given inside the school system? Yes ☐ No ☐

If yes, describe: _____

Other additional Info you would like to share: _____

How did you hear about Sensory Solutions? _____

What are your goals for therapy

1. _____

2. _____

3. _____

4. _____

5. _____