



Functional Integrated Therapeutic Services
 5945 Pacific Center Blvd. Ste 510
 San Diego, CA 92121
 (858)695-9444

This information to be shared with FITS OT and FITS PT

Child's Name: _____ **Birthdate:** _____ **Today's Date:** _____

Please check (✓) the column which best describes your child. After each item and category, please write any remarks or comments that you feel may be helpful. Please include child's strengths in comment areas.

Perinatal History (Pregnancy)

During your pregnancy did you experience any of the following? (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Illnesses | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Injuries | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Surgical Operations | <input type="checkbox"/> List any Medications: _____ |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: _____ |

The pregnancy was:

- Full Term: Months _____ Birth Weight _____
 Premature: Months _____ Weeks _____ Days _____

Maternal Age at Delivery: _____ years

Birth Order: 1st 2nd 3rd Other: _____

Name and age of siblings:

Labor Information (Please check all that apply)

- Normal Prolonged Short

Delivery Information (Please check all that apply)

- Vaginal Breeched Caesarean
 Forceps used Medication used during delivery: _____
 Other:

Apgar Score:

1 minute _____ 5 minutes _____ 10 minutes _____

Following delivery did your child experience any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Cyanosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Intubation |
| <input type="checkbox"/> Congenital Defects | <input type="checkbox"/> Apnea/Bradycardia | <input type="checkbox"/> Delayed Cry |
| <input type="checkbox"/> Limpness | <input type="checkbox"/> Catheter | <input type="checkbox"/> Other: _____ |

Was there a need for any of the following?

Oxygen/Ventilator Transfusions Tube Feedings Surgery Other: _____

Length of stay at the hospital? _____ days NICU stay _____ days

Describe your child as a newborn/infant:

<input type="checkbox"/> Cried a lot, fussy, irritable	<input type="checkbox"/> Active	<input type="checkbox"/> Had Regular sleep patterns
<input type="checkbox"/> Non-demanding	<input type="checkbox"/> Liked being held	<input type="checkbox"/> Had irregular sleep patterns
<input type="checkbox"/> Alert	<input type="checkbox"/> Resisted being held	
<input type="checkbox"/> Quiet	<input type="checkbox"/> Floppy when held	
<input type="checkbox"/> Passive	<input type="checkbox"/> Tense when held	

Feeding

The child was:

Breast Fed If yes, how long? _____ Frequency _____

Bottle Fed Type of Formula _____ Amount _____ Frequency _____

Modifications to Nipple? Yes No

Did the child have a strong suck?

Yes No

Did the child spit up frequently?

Yes No

Medical History

Has your child experienced any of the following?

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Lung difficulties	<input type="checkbox"/> Meningitis
<input type="checkbox"/> High Fevers	<input type="checkbox"/> Bronchial difficulties	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cleft Palate
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tremors
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Excessive Vomiting	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	

Seizures: When _____ How often _____ Medications _____

Heart defect: Type _____ Medications _____

Allergies: Please list _____ Medications _____

Physical Injuries: _____

Operations (Date, Describe): _____

Other Medications (Currently Taking, please describe) _____

Has your child ever been exposed to the HIV virus?

No Yes: Comments _____



Has your child ever been exposed to Hepatitis B?

No Yes: Comments _____

Has your child ever been exposed to Tuberculosis?

No Yes: Comments _____

Vision Information

Has your child had an eye evaluation?

No Yes If so, Optometrist Name _____ Date of Exam _____

Ophthalmologist Name _____ Date of Exam _____

Vision Therapist Name _____ Date of Exam _____

Does your child have a vision challenges?

No Yes: Describe _____

Does your child have eye muscle imbalance?

No Yes

Does your child wear glasses?

No Yes: If yes, describe _____

Does your child?

- Appear to be happier in the dark
- Picks up pictures or objects and looks very closely and carefully at them
- Becomes excited when there is a variety of visual objects
- Squint often
- Wear glasses
- Have difficulty maintaining eye contact with another person
- Have difficulty visually following an object tossed or rolled towards him/her
- Shift their head from one side or the other in order to look at something
- Tend to reach too far or not far enough when playing, eating, etc.

Hearing Information

Does your child?

- | | |
|--|--|
| <input type="checkbox"/> Respond negatively to unexpected noises | <input type="checkbox"/> Seems to enjoy strange noises and/or make loud noises |
| <input type="checkbox"/> Respond negatively to loud noises | <input type="checkbox"/> Appears to be hard of hearing |
| <input type="checkbox"/> Have difficulty paying attention where there are other noises nearby? | <input type="checkbox"/> Enjoys music |
| <input type="checkbox"/> Miss hearing some sounds | <input type="checkbox"/> Has a diagnosed hearing loss |
| <input type="checkbox"/> Seems confused as to the direction of sounds | <input type="checkbox"/> Wears a hearing aid |
| | <input type="checkbox"/> Has difficulty understanding what is said |

Has your child had a hearing evaluation?

No Yes If so, Doctor Name _____ Date of Exam _____

Does your child have hearing challenges?

No Yes: Describe _____

Does your child have a history of ear infections?

No Yes: Frequency _____

Has your child had ear tubes placed?

No Yes

Medical Examinations

Has your child had any of the following examinations? If so, please give the approximate date and the examining person's name and phone number.

Examination	Date	Treating Physician	Physician's Phone #
Physical Examination			
Neurology			
Pneumogram			
Psychiatry			
Psychology			
Education			
Speech			
Audiology			
Other (e.g. Orthopedist, Podiatrist, Cardiologist):			
Other:			

Developmental History

Please note the approximate age at which age your child did the following:

Rolled over both ways: _____

Sat Alone: _____

Held Head Up (on stomach): _____

Belly crawled: _____

Crawled on hands and knees: _____

Pulled to stand: _____

Stood alone: _____

Cruised: _____

Walked: _____

Spoke first words (what was it): _____

Spoke first sentence (what was it): _____

Drank from a cup independently _____

Used a spoon independently _____

Feed himself independently _____

Please check the following Skills that your child can do independently:

- | | |
|--|---|
| <input type="checkbox"/> Dress self | <input type="checkbox"/> Zip/Unzip |
| <input type="checkbox"/> Undress self | <input type="checkbox"/> Needs Assistance with bathing |
| <input type="checkbox"/> Needs assistance with dressing/undressing | <input type="checkbox"/> Drink from an open cup independently |
| <input type="checkbox"/> Put on a jacket | <input type="checkbox"/> Holds bottle independently |
| <input type="checkbox"/> Snap/unsnap | <input type="checkbox"/> Cut with a knife |
| <input type="checkbox"/> Take shoes off | <input type="checkbox"/> Drink from a straw |
| <input type="checkbox"/> Tie Shoes | <input type="checkbox"/> Finger feed self |
| <input type="checkbox"/> Put shoes on correct feet | <input type="checkbox"/> Scoop with a spoon |
| <input type="checkbox"/> Bathe Self | <input type="checkbox"/> Use a fork (including stabbing food) |
| <input type="checkbox"/> Unbutton/Button | |

Is your child toilet trained?

- No
 Yes: Age trained _____
Bladder _____ Daytime only? Yes No
Bowel _____ Daytime Only? Yes No

Hand Dominance: Right Left Unknown

Feeding

Does your child currently eat?

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Baby food | <input type="checkbox"/> Mashed Table foods |
| <input type="checkbox"/> Junior food | <input type="checkbox"/> Table Foods |

Does your child object to any of the following?

- Certain food texture: If yes, explain _____
 Certain tastes: If yes, explain _____
Other: _____

Does your child?

- Act as though all foods taste the same
 Chews on non-food objects
 Have unusual craving for certain foods
 Dislike food of certain texture

Does your child feed themselves? Please describe any difficulties:

- | | |
|---|---|
| <input type="checkbox"/> All of the time | <input type="checkbox"/> Some of the time |
| <input type="checkbox"/> Most of the time | <input type="checkbox"/> Rarely |
- Difficulties _____

Olfactory (Smell)

Does your child?

- | | |
|--|--|
| <input type="checkbox"/> Explore by smelling | <input type="checkbox"/> React negatively to smell |
| <input type="checkbox"/> Discriminate odors | <input type="checkbox"/> Ignore unpleasant odors |



Gross Motor Development

Does your child?

- Spend time playing while lying on stomach
- Have generally good posture while standing/sitting
- Have good balance
- Appear clumsy, often bumping into things or falling down

Fine Motor Development

Does your child?

- Manipulate objects easily
- Have difficulty with paper and pencil activities
- Have difficulty fastening/unfastening clothes?

If yes, what type _____

- Shift position constantly while standing

- Shift position constantly while sitting
- Have a weak grasp
- Like puzzles, manipulative toys
- Appear clumsy when playing with toys
- Have trouble using scissors

School Performance

Does your child?

- Have difficulty completing tasks
- Takes an excessive amount of time to complete homework
- Appear disorganized
- Have difficulty organizing multi-step tasks (i.e., book, report)

- Show immature social interactions
- Have poor peer relations
- Follows directions well
- Stays on task

Additional Comments:

Tactile

Does your child?

- Avoid playing with “messy” things (i.e. paint, paste, mud, sand, etc)
- Dislikes having face washed or wiped
- Appear to be irritated by cloth or certain textures Specify:

-
- Object to being touched
 - Dislike being touched unexpectedly
 - Dislike being cuddled
 - Prefer to touch rather than be touched
 - Avoid using hands for extended periods

- Bangs their head on purpose now or in the past
- Pinch, bite, or otherwise hurt themselves or others
- Examine objects by putting them into their mouth
- Tend to feel pain more or less than others
- Frequently bump and push other children
- Dislike hair washing/nail cutting
- Seem excessively ticklish



Proprioceptive

Does your child?

- Hold their hands in strange positions
- Hold their body in strange positions
- Have awareness of his body in space
- Have movements that are abrupt and quick in quality
- Have poor ability to move slowly from one position to another

Vestibular (Movement)

Does your child?

- | | |
|---|---|
| <input type="checkbox"/> Rock while sitting | <input type="checkbox"/> Like merry-go-rounds |
| <input type="checkbox"/> Jump a lot | <input type="checkbox"/> Spin and whirl more than other children |
| <input type="checkbox"/> Like being tossed in the air | <input type="checkbox"/> Get car sick |
| <input type="checkbox"/> Seem fearful of movement | <input type="checkbox"/> Enjoy being rocked now or as an infant |
| <input type="checkbox"/> Seem fearful of space (i.e. going up and down stairs, riding a teeter totter, going through small enclosed spaces) | <input type="checkbox"/> Have no fear of moving or falling |
| | <input type="checkbox"/> Become irritable during long car rides |

Comments:

Behavior

Your child at present:

- | | | |
|---|--|--|
| <input type="checkbox"/> Is mostly quiet | <input type="checkbox"/> Has frequent tantrums | <input type="checkbox"/> Makes friends easily:
If no, please describe

_____ |
| <input type="checkbox"/> Is overly active | <input type="checkbox"/> Has difficulty separating
from primary caretaker | |
| <input type="checkbox"/> Tires easily | <input type="checkbox"/> Has nervous habits or tics | |
| <input type="checkbox"/> Talks constantly | <input type="checkbox"/> Has short attention span | |
| <input type="checkbox"/> Very impulsive | <input type="checkbox"/> Is easily frustrated | <input type="checkbox"/> Engage in unusual or
repetitive behavior |
| <input type="checkbox"/> Is restless | <input type="checkbox"/> Has unusual fears | <input type="checkbox"/> Difficulty transitioning
from one activity to another |
| <input type="checkbox"/> Is stubborn | <input type="checkbox"/> Rocks self frequently | |
| <input type="checkbox"/> Is resistant to change | <input type="checkbox"/> Has difficulty learning new
tasks (i.e. throwing a ball,
building blocks) | |
| <input type="checkbox"/> Over reacts | | |
| <input type="checkbox"/> Fights frequently | | |
| <input type="checkbox"/> Is usually happy | | |

Sleep

Does your child sleep well? Yes No Hours per night _____

Please explain _____

Does your child take a nap?

Yes No If yes, how long _____

TV/Games

Amount of exposure to TV/Video Games/Computer per day _____



Family History

Please indicate if there is a family history of the following:

- | | |
|---|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Speech and Language delays |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Anxiety disorders |
| <input type="checkbox"/> Neurological Disorders | |

List your child's preferred activities and special interests:

List any significant activities/items that your child dislikes:

Parent Concerns:

Additional Information you may wish to share (include any specific goals or expectations you would like accomplished through therapy)
