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GLORY THERAPY

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Physical Therapy, Occupational Therapy, & Speech Therapy

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Identifying Information

Child's Legal Name _____ Nickname: _____

Date of Birth: _____ Age: _____ Date History Form Completed: _____

Parents/Legal Guardian Name(s): _____

Address: _____

Mailing Address (if different): _____

Person Completing this form: _____ Relationship: _____

Mother's Employment: _____ Job Title: _____

Mother's Daytime Phone: _____ Evening Phone: _____

Father's Employment: _____ Job Title: _____

Father's Daytime Phone: _____ Evening Phone: _____

Email address: _____

Child's Social Security Number: _____ Do you have Medicaid? Y___ N_____

If yes, please provide your policy/card #: _____

Name of family doctor or referring physician: _____

Phone Number of family doctor/ referring physician: _____

Name of Primary Insured: _____

Referral Information

Who referred the child to this clinic? _____

_____Pediatrician _____Relative _____Parent _____Teacher _____Friend _____Other

Would you like the referring physician to receive a copy of the report? _____Y _____N

Address: _____

Fax: _____Physician's Nurse_____

Are there others who should receive a copy of the report? _____Y _____N

Name: _____

Address: _____

What is the reason for referral (please check all that apply?

_____Diagnosis ____School Placement _____Treatment _____Consult _____Other

If other, please explain: _____

Briefly describe your concern: _____

_____

Family History

Mother's Name: _____Age: _____Highest Degree/Grade: _____

Father's Name: _____Age: _____Highest Degree/Grade: _____

Sibling's Name: _____Age: _____Highest Degree/Grade: _____

Name: _____Age:_____Highest Degree/Grade: _____

Name: _____Age: _____Highest Degree/Grade: _____

Others living in the home:

Name/ Ages: _____Relationship: _____

Has anyone else in the family received speech of language services? _____Y _____N

If so, please explain? _____

Has anyone in the family had attention or behavior problems?_____

Educational History

Name of current Preschool/School: _____

Grade: _____Primary Placement: _____ Regular Educational Classroom

_____ Self-Contained Classroom (Full Day) _____Resource Time

_____ 504/IEP _____ Other _____

Teacher's Name: _____

Describe the child's progress in school: _____

Describe your concerns about school ____Reading ____Math ____Spelling ____Handwriting ____Writing Sentences
____Attention ____Organization ____Study Habits _____Complex Directions _____Rhyming ____Phonics

Does the child receive any of the following services? ____Speech/Language ____OT ____PT ____APE ____Counseling

How long has child participated in therapy? ____< 6 months ____< 1 year ____1+ or more yrs ____Individual ____Group

Primary focus of therapy: _____

Pregnancy and Birth History

Is this child your biological child? _____Y _____N Adopted_____

Did the birth mother have any illnesses, accidents, unusual stress or shock during the pregnancy? _____Y _____N
If yes, please comment:_____

Did the birth mother receive/take any prescribed medications while pregnant? _____Y _____N If yes, what medications and for how long? _____

Were the medications used during: _____first trimester _____second trimester _____third trimester

Did the birth mother drink alcohol or use any illegal drugs while pregnant? _____Y _____N If yes, what substances and for how long: _____

Were there any infections or complications during the pregnancy (high blood pressure, Gestational Diabetes, Preeclampsia)
If yes, please comment:_____

Where there any complications during the labor and/or delivery process? _____Y _____N If yes, please comment:_____

What was the baby's birth: _____Premature _____Weeks _____Term _____Late ___Weeks

Type of delivery: _____Vaginal _____ Caesarian _____Forceps Used _____Vacuum Extraction

What was the baby's birth weight? _____Pounds _____Ounces APGAR Score: _____

Did the baby have difficulty with any of the following in the first 48 hours following birth?

_____ Breathing _____Crying _____ Sleeping _____ Jaundice

_____Response to noise _____Sucking _____Feeding _____Other

If other, please comment: _____NICU stay_____

How long did the baby remain in the hospital following birth? _____

Developmental Feeding

Was your child breast-fed? __Y _____N If yes, how long?_____

Were there any problems with this (Ex: poor suck, slow to feed)? _____

When was your child weaned from bottle/breast?_____

When did the child start to feed him/herself? _____

When did your child start to eat solid foods? _____

Were there any problems with transitioning to chunky solids? (example: gagging, choking, spitting) _____Y _____N

Does your child refuse to eat, spit out, or gag on foods based on the following:	NO	YES (Circle all that apply)					
		Temperature	Food Texture	Crunchy Food	Chewy Foods	Food Color	Mixed Textures
		Please Comment with examples:					
Does your child have difficulties with any of the following:	NO	YES (Circle all that apply)					
		Food Variety	Chewing/Swallowing a variety of foods	Sucking through a straw	Managing mixed food textures	Stuffing food in mouth	Frequent Choking
		Please Comment:					
Does your child exhibit oral motor sensitivities or seeking measures:	NO	YES (Circle all that apply)					
		Examines objects by placing in mouth		Gags/Vomits frequently		Bites/Chews objects or clothing frequently	Grinds Teeth

Does your child attempt to eat unusual, noxious or inedible substances? ____N _____Y Example_____

Does the child drink juice? __Y _____N If yes, how much in a day? _____

Is the juice given before, during, or after a meal? (Please circle.) Before During After

Does your child exhibit any of the following behaviors during feeding?

_____Crying _____spitting food out of his/her mouth _____holding food in his/her mouth

____gagging _____regurgitating food _____getting down from the table from the table during meal

How many times a day does your child eat? _____

If your child does not feed him/herself, who feeds him/her? _____

Where does your child eat? _____Who else is present for meals? _____

How is your child positioned when eating (sitting in high chair, table, floor, standing)?_____

Does your child eat more/less, same, different foods when he/she is at daycare/sitter/grandparents? (Please circle and describe) _____

What consistency of foods does your child eat? _____

How much liquid does your child drink at each meal? ~____ cups How much food does your child eat at each meal? __ servings

How long does each meal take? _____Mins What do you do when your child does not eat appropriately? _____

What are some of your child's favorite foods?_____

If different from favorite foods, what are some easy foods for your child to eat? _____

Which foods will your child not eat? _____

List some good things that your child does at meal times (e.g., sits at the table, eats certain foods)

_____

List some things that you things your child should not be doing at meals (e.g., having a tantrum, throwing food)

_____

What have you tried to do to help your child with eating more? _____

Please describe any other feeding problems(s) that your child is experiencing: _____

Developmental History

I have been concerned about my child's development: _____Y _____N Speech Fine Motor Gross Motor

I am concerned about my child's development because: _____

_____

Please indicate the approximate ages at which each of the following occurred for the first time:

Cooing		Sit Unassisted		Feed Self w/Hands	
Babbling		Stand Alone		Feed self w/ utensils	
Single Words		WALK		Dress Self	
Combine Words		Climb Stairs		Toilet Trained	
Ask Questions		Jump w/both feet		Ride Tricycle	

Has your child lost the ability to do any of the above milestones? If yes, please specify:_____

Does your child use any adaptive equipment/braces? If yes, please specify:_____

Does your child have a nurse or home health aid that comes to assist with daily tasks? If yes, please specify:_____

What time does your child awaken?_____What mood is your child in upon waking?_____

What time does is your child put to bed?_____ How long before falling to sleep?_____

Where does child sleep?_____ Sleep through night? Y N Wakes: 1-2 times 3-4x's 5+ a night

What does child do when he/she awakens:	Whimper	Screams	Play with toys	Go to parent's bedroom	Puts self back to sleeep	Other:

What activities do you use to put child back to sleep:		Feeding	Singing	Humming	Holding/rocking	Bouncing	Massage	Other
Bedtime routines or activities performed	NO	BATH	Reading	Rocking/Holding	Singing/Humming	Bouncing	Massage	Lay down with

At what age did child sleep through night?_____ Does child require: too little/too much sleep? Hours each day_____

Does child take naps?_____N _____Y Duration of naps?_____Frequency of naps? _____x's per day

Does child need help to fall asleep for naps?____N _____Y Where does child take naps?_____

Medical History

Please check all that apply and provide clarifying information under "comment"

Illness	**Comment/About When**		
Allergies		**YES**	**NO**
Recurrent colds/flu/sore throat		**YES**	**NO**
Frequent Ear Infections		**YES**	**NO**
Strep Throat		**YES**	**NO**
Autism		**YES**	**NO**
Toxic Exposure (lead, mercury, pesticides)		**YES**	**NO**
Traumatic Brain Injury		**YES**	**NO**
Dizziness		**YES**	**NO**
Dental Problems		**YES**	**NO**
Frequent laryngitis/hoarseness		**YES**	**NO**
Vocal Nodules		**YES**	**NO**
Epilepsy/seizure disorder		**YES**	**NO**
Tic Disorders (Chronic motor or vocal, Tourette's)		**YES**	**NO**
Autoimmune Dysfunction		**YES**	**NO**
Gastrointestinal (Stomach) Problems		**YES**	**NO**
Swallowing/digestive disorders		**YES**	**NO**
Reading and/or spelling problems		**YES**	**NO**
Other academic problems		**YES**	**NO**
Past Head Injuries/Head Trauma/Concussions		**YES**	**NO**
Attention Deficit Disorder (ADD/ADHD)		**YES**	**NO**
Digestive Problems/Stomach Pain		**YES**	**NO**
Failure to gain weight/Diarrhea/Constipation		**YES**	**NO**
Vision Difficulties (eye strain, headaches, eye infection)		**YES**	**NO**

High Fevers _____ YES NO

Kidney/Renal Disorder _____ YES NO

Urinary Problems/Infections _____ YES NO

Respiratory difficulties/Asthma _____ YES NO

Heart/circulatory problems _____ YES NO

Neurological Disorders _____ YES NO

Seizures or Convulsions _____ YES NO

Cancer _____ YES NO

Endocrine/metabolic disorders (hormonal, thyroid, diabetes) _____ YES NO

Viruses (HIV, Herpes, Hepatitis, Mono) _____ YES NO

Connective Tissue Disorders (Lupus, Rheumatoid Arthritis) _____ YES NO

Muscle Disorder/Muscle Problem _____ YES NO

Joint Problems or Bone Fractures _____ YES NO

RSV _____ YES NO

Skin Disorder/Skin Problems _____ YES NO

Sleep Disorder _____ YES NO

Frequent or intense headaches _____ YES NO

Measles/Mumps/Chicken Pox _____ YES NO

Birth Defect/Genetic Disorder _____ YES NO

Anemia/Blood Disorder _____ YES NO

Meningitis _____ YES NO

General Health: _____ Excellent _____ Good _____ Fair _____ Poor

Please indicate any ongoing medical conditions: _____

Has your child ever been seen by any of the following specialists? Check all that apply:

____ ENT ____ Psychologist ____ Nutritionist

____ Neurologist ____ Behavior Specialists ____ Orthodontist

____ Psychiatrist ____ Physical Therapist ____ Speech Therapist

____ Occupational Therapist ____ Other _____

Please list names/approximate dates/reason for specialist:

Name: _____ Date: _____

Reason for Involvement: _____

Name: _____ Date: _____

Reason for involvement: _____

Please list previous surgeries/illnesses/injuries/hospitalizations

Problem	Dates	Comments

Please circle the appropriate column:	1- Never/rarely	2- Occasionally	3- Typical for age	4- Frequently	5-Always
Diarrhea	1	2	3	4	5
Stomach ache	1	2	3	4	5
Vomiting	1	2	3	4	5
Head ache	1	2	3	4	5
Constipation	1	2	3	4	5
Ear ache	1	2	3	4	5

Present Communication Status

Please describe your child's speech: _____

Have diagnostic services related to the speech problem previously been received? _____Y _____N

If yes, by whom and when? _____

Results of previous diagnosis: _____

When did the problem first begin? _____

Has the problem: _Remained the same _____ gradually worsened _____worsened quickly

In your opinion, does the child's speech/language problem have an effect on his/her ability to communicate? _____Y _____N
If yes, please explain: _____

In your opinion, does the child's speech/language problem affect the performance of his/her daily activities? _____Y _____N
If yes, please explain: _____

Audiological/Auditory History

My child had 3+ ear infections between birth and 12 months of age _____Y _____N

My child has had at least 1 ear infection that lasted more than 3 months _____Y _____N

My child has been evaluated by an audiologist who determined that his/her hearing is within normal limits.

Date of visit: _____ _____Y _____N

If hearing was not determined within normal limits please explain: _____

My child has failed a hearing screening in school. Date of screening:_____ _____Y _____N

My child passed a hearing screen in school. Date of screening: _____ _____ Y _____ N

My child prefers one ear over the other. If yes, which ear_____Right _____Left _____ No

My child has tubes in his/he ears. If yes, when? _____ ____Y _____N

My child wears hearing aids. If yes, what type and for how long? _____ ____Y _____N

Comments:_____

Does your child demonstrate fear or obsession of the following noises/devices?	Vacuum Cleaner	Hair Dryer	Blender	Toilet Flushing	Air Vents	Other
	Please Comment:					
Does your child hear sounds that others do not or before others notice?	NO					
	YES, Please Comment:					
Does your child have difficulty paying attention in noisy environments?	NO					
	YES, Please Comment:					
Does your child cover ears to shut out noises?	NO					
	YES, Comment on specific sounds:					
Does your child struggle when there is excessive auditory input in his/her environment?	NO	YES				
		How does your child react:	Cover Ears	Run to avoid or want to hide	Cry	OTHER
Does your child struggle around people with certain voice pitches?	**NO**	**YES, Please comment:**				

Speech and Language History

Is English the child's native language? _____Y _____N

If not, what is the child's native language? _____

How many languages are spoken in the home? _____ Which languages? _____

My child follows directions well. _____Y _____N

My child gives directions well. _____Y _____N

My child asks for help when needed. _____Y _____N

He/She expresses self in a coherent manner that is understood to others. _____Y _____N

My child likes to have stories read to him/her. _____Y _____N

How long does he/she attend the story?_____

My child plays with toys appropriately for his/her age. _____Y _____N

My child communicates primarily through whining/crying. _____Y _____N

My child communicates primarily through gesturing/ pointing. _____Y _____N

My child tries to communicate through verbalizing but cannot be understood. _____Y _____N

My child primarily uses one-word utterances to communicate. _____Y _____N

My child primarily uses two-word phrases to communicate. _____Y _____N

My child primarily uses 3+ words to communicate. _____Y _____N

My child uses proper sentence structure for most of his/her utterances. _____Y _____N

My child's communication efforts are easily understood by familiar persons. _____Y _____N

My child's communication efforts are easily understood by unfamiliar persons. _____Y _____N

My child frequently drools. _____Y _____N

My child has difficulty chewing his/her food. _____Y _____N

My child has difficulty swallowing his/her food. _____Y _____N

I am concerned about how well my child's speech can be understood. _____Y _____N

I am concerned about my child's language development (the content of what he/she says; how well he/she understands what others say. _____Y _____N

Please circle the appropriate column:	1- Never/rarely	2- Occasionally	3- Typical for age	4- Frequently	5-Always
Initiates eye contact when greeted	1	2	3	4	5
Initiates eye contact when talking	1	2	3	4	5
Sustains eye contact	1	2	3	4	5
Takes turns.	1	2	3	4	5
Interacts with peers	1	2	3	4	5
Interacts with adults.	1	2	3	4	5
Participates in conversations	1	2	3	4	5
Responds to questions in a timely manner	1	2	3	4	5

If your child is nonverbal, please describe how and the types of vocalization your child uses_____

_____

If your child is nonverbal, please describe how your child communicates and gives examples_____

If your child is verbal, please describe your child's verbal abilities (i.e. vocabulary, ability to stay on topic, etc.) _____

Overall, I would rate my child's speech intelligibility as:___Excellent ___Good ___Fair ____Poor ____Mostly Unintelligible

Overall, others would rate my child's speech intelligibility as:___Excellent ___Good ___Fair ___Poor ____Mostly Unintelligible

Comments: _____

Social/ Emotional Components

Does your child exhibit tantrums?	**NO**	How frequently do they occur? _____times per day _____time of day _____times per week			
		What triggers tantrums?			
		On average, how long do the tantrums last?			
		Strategies that are effective for helping calm child during tantrum:			
Does your child easily escalate from whimper to intense crying? **NO**	**YES**	**Please Comment:**			
Does your child demonstrate any of the atypical repetitive behavior/behaviors?	**NO**	Hand flapping	Rocking	Head banging	Jumping
		Smelling food/objects	Self-talk	Mouthing objects	Humming
		Visual fixing	Breath holding	Spinning	Teeth grinding
Does your child have difficulty separating from parent or caregiver?	**NO**	**YES, Please Comment:**			
Does your child lack a fear of strangers?	**NO**	**YES**			
How does your child react in new/unfamiliar environments/situations?	**Specify:**				
Does your child struggle with transitions? No	How long doe it take to transition, on average?		What transitions are difficult?		
	What strategies are used to help ease transitions?		Does difficulties cause distress to other family members?		

Please circle the appropriate column:	1- Never/rarely	2- Occasionally	3- Typical for age	4- Frequently	5-Always
Complaining	1	2	3	4	5
Displays affection toward others	1	2	3	4	5
Displays aggression toward self	1	2	3	4	5
Displays aggression toward others	1	2	3	4	5
Irritable	1	2	3	4	5

Cries easily	1	2	3	4	5
Seems happy	1	2	3	4	5
Seems immature for age	1	2	3	4	5
Displays rapid mood swings	1	2	3	4	5
Seems independent	1	2	3	4	5
Seems dependent on others/clingy	1	2	3	4	5
"Baby talks"	1	2	3	4	5
Requires a lot of comfort/nurturing	1	2	3	4	5
Over reacts to accidents/pain	1	2	3	4	5
Seems impulsive	1	2	3	4	5
Accept changes in routine	1	2	3	4	5
Easily frustrated, anxious or overwhelmed	1	2	3	4	5
Accident-prone	1	2	3	4	5
Seems to withdraw from groups	1	2	3	4	5
Easier to handle in small group/individually	1	2	3	4	5

Does your child exhibit any of the following symptoms? Check all that apply:

☐ Absent facial gestures	☐ Fatigue/listlessness
☐ Sluggish/jittery movements	☐ Low motivation
☐ Asks to use restroom during testing	☐ Hopelessness
☐ Destructive rages (past age 4)	☐ Helplessness
☐ Talks of wanted to harm themselves	☐ Irritability
☐ Difficulty changing activities/perseverative	☐ Anger
☐ Unwanted thoughts/impulses	☐ Excessive worry
☐ Anxiety about thoughts/impulses	☐ Irritable
☐ Unique concern about correctness of answers	☐ Clingy with parents/caregiver
☐ Insisting something to be done in a certain way	☐ Blames others
☐ Very picky about performance	☐ Frequent temper tantrums
☐ Appears skittish/easily startled	☐ Active defiance of instructions

☐ Racing thoughts/speech	☐ Concerned with performance
☐ Excessive arguing with adults	☐ Seeks revenge
☐ Uses mean and hateful words when upset	☐ Serious violation of rules
☐ Aggressive behaviors to Self Others	☐ "You can't make me" statements

Examples:_____

_____

_____

Self-Care Skills

Does child dislike or resist the tactile feeling of grooming activities:	Brushing Teeth	Hair brushing	Face washing	Haircuts	Nail trimming	Blowing nose	Bathing
	Circle all that apply and please comment:						
Does child have difficulties completing activities in a coordinated manner or independently?	Brushing Teeth	Hair brushing	Face washing	Dressing Self	Bathing Self	Blowing Nose	Other:
	Circle all that apply and please comment:						
Does child avoid the sound or fear the feeling of any of the following?	Hair dryer	Toilet flushing	Barber's Clippers	Hand dryer	Dentistry Tools	Bath Water	Electric Toothbrush
	Circle all that apply and please comment:						

Child can remove the following:	Shirt	Pants/Shorts	Underwear	Shoes	Socks	Coat
Child can dress self independently:	Shirt	Pants/Shorts	Underwear	Shoes	Socks	Coat

Which fasteners can child perform:	Snaps	Zippers	Button/Unbutton	Shoe Tying What Age: Struggle? Y N
Is child selective in type of clothing textures he/she will wear? NO	Clothing type preferred	Clothing type avoided	Do tags and sock seams bother your child? Y N	Adjust clothing frequently Unaware of clothing alignment
Toilet Trained? What Age For:	Bladder	Bowel	Accidents N Y When/Where?	Pull-Up at night? Y N

Play Skills/Peer Interaction/School Skills

How long is your child able to play alone?	1-2 minutes	2-5 minutes	5-10 minutes	10-30 minutes	30+ minutes

What are your child's preferred play activities:	Please Specify:				
How much time is spent daily doing the following?	TV, Computer, Phone, Tablet	Movement Activities	Learning/Interactive		Video Games
Is your child destructive toward toys? NO	Yes: Please Comment:	Does your child struggle to play alone? NO		Yes: Please Comment:	
Does your child struggle playing with other	YES	Interactive Play	Structured Group Play	Making Friends	Pretend Play

children? **NO**							
Is your child preoccupied with seeking intense movement during play? NO	YES	Spinning	Jumping	Crashing	Rocking	Bouncing	Other(s):
Does your child have a strong sense for structure or control? **NO**	YES, Please comment:						
Does your child exhibit poor safety awareness or engage in activities that are potentially dangerous (jumping, climbing without regard) **NO**	YES, Please comment:						
Where does your child attend preschool or school?	Home School	Daycare	Regular Class	Special Education	Pre-K	Other	
Which of the following "messy" activities does your child avoid: **Circle all that apply**	Sand	Finger Paint	Play-dough	Glue	Sticky Fingers	Other	
Which surfaces does your child have difficulty with:	Stairs	Grass	Woodchips	Sand	Gravel driveways	Other	
Does your child exhibit a hand preference? NO	Right Left Established at what age?			Does your child frequently change his/her grasp on pencils/ other tools? YES NO			
Which writing skills/activities does your child struggle with or avoid:	Coloring	Tracing	Copying	Writing, spacing	Pencil Pressure	Holding Paper when writing or coloring	
Which of the following visual-related skills does your child struggle with: **Circle all that apply**	Eyes close to work	Rereads or skips words	Cover one eye to read	Reading comprehension	Reverse letters or words	Moves head instead of eyes to track moving object (ball)	
	Eye strain after reading for short time	Short attention in reading or writing	Use of finger to keep place in reading	Losing place often when reading or writing	Copying form board to paper	Poor posture when reading or when doing writing work	
Does your child have difficulty sitting still?	**NO**	**YES**	Does your child fidget while listening? **NO** **YES**				
Does your child seem to need to "fix" the environment (arrange objects, chairs, etc)?	**NO**	**YES**	**Please Comment:**				