MELANIE MASSEY PHYSICAL THERAPY

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Our Mission: To joyfully use our gifts to brighten the lives of others.

At ***Melanie Massey Physical Therapy***, we strive to provide your child with a thorough evaluation. In order to do so, we ask that you take the time to fill out this information regarding your child's developmental history. This will allow our therapists to identify any areas of concern. All information is considered confidential. Thank you for putting your trust in ***Melanie Massey Physical Therapy.***

Child's Name: _____Date:_____

DOB: _____Age: _____Sex: ___Female ___Male

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone(s):_____Preferred contact number:
___Home ___Cell ___Work Person completing this form: _____

Relationship to patient: _____

PARENT INFORMATION:

Father: _____ Age: _____

Mother: _____ Age: _____

Step-Father: _____ Age: _____

Step-Mother: _____ Age: _____

Guardian: _____ Age: _____

BACKGROUND INFORMATION:

Other adults in the home and their relationship to the child:

_____

_____

Language(s) spoke in the home other than English: _____

If other languages are spoken, which did your child learn first? _____

In school, is your child receiving any of the following services: ___Regular Education ___Special Education ___ APE ___Physical Therapy ___Speech Therapy ___Occupational Therapy

List all physicians child is seeing

Physician	Specialty	Phone Number

Who referred you to this facility? _____

Reason for referral? _____

What concerns do you or family members have about this child?

_____

_____

_____

_____

BIRTH HISTORY:

Length of pregnancy: _____ Did mother smoke? ___Yes ___No

Did mother drink? ___Yes ___No

What medications did birth mother receive? _____

_____

Describe any problems during the pregnancy? _____

_____

_____

Birthweight: ___lb. ___oz. Length:_____ inches

Duration of labor: _____Anesthesia used: _____

Hospital: _____ Physician: _____

Type of delivery: ___Vaginal ___Caesarean ___Forceps ___Vacuum

Any labor complications (i.e. baby's position, cord around neck, breathing difficulties)? _____

Did mother receive blood during or after delivery? ___Yes ___No

Did child? ___Yes ___No Did baby need oxygen? ___Yes ___No

Was baby in ___regular nursery ___special care nursery?

Was baby placed in incubator? ___Yes ___No

Duration of baby's hospital stay? _____

Has your child ever been diagnosed with CMV (cytomegalic virus?) ___Yes ___No

DEVELOPMENTAL HISTORY:

Any current or past difficulties with ___sucking ___swallowing ___chewing?
Please describe: _____

_____

Note the ***AGE*** at which your child accomplished the following:

Held head up _____ Crawled: _____ Rolled over: _____ Stood alone: _____

Sat without support: _____ Walked alone: _____ Toilet trained: _____

Any other problems? _____

Describe your child's attention span: _____

_____

How does your child get along with other children? _____

_____

_____

MEDICAL HISTORY:

List any special test, procedures, and/or hospitalizations since birth MRI, EEG):

Date	Procedure	Reason for Testing	Results of Procedure

History of disease and frequency (e.g. colds, earaches, bronchitis, high fever, convulsions) _____

_____

_____

_____

Does your child require supplemental oxygen? ___Yes ___No Describe: _____

_____

_____

_____

Does your child have a VP shunt? ___Yes ___No

Does your child have a feeding tube? ___Yes ___No

MMPT is *NOT* Responsible for Trach or Feeding Needs

_____INITIAL

Has your child had any of the following conditions?

___ Motor difficulties ___ Physical Weakness

___ Temper tantrums ___ Seizures

___ Head banging ___ Ear infections

___ Staring Spells ___ Drooling

List any additional medical precautions: _____

Has your child had his/her hearing screened? ___Yes ___No

If yes, where? _____ When? _____

Results: _____

Has your child had his/her vision screened? ___Yes ___No

If yes, where? _____ When? _____

Does your child wear glasses? ___Yes ___No

Any allergies? ___Yes ___No

If yes, describe: _____

_____

Is your child currently on any medications? ___Yes ___No Please list below

Medication	Dosage	Oral/Nasal	Frequency	Physician	Start Date	Stop Date

PLAY SKILLS:

What does your child like to play with? _____

_____

What does your child dislike playing with? _____

SELF HELP:

Has your child ever used feeding utensils? ___Yes ___No If yes, is assistance needed for success? Please describe: _____

_____

How much assistance is needed (if any) with self dressing? _____

_____

Can your child complete buttons, zippers, snaps? ___Yes ___No

Can your child independently drink from a cup? ___Yes ___No

MOTOR SKILLS:

Has or does the child use braces or orthotics? ___Yes ___No

Has or does child use any assistive devices? ___Yes ___No

Has child seen an orthopedic doctor? ___Yes ___No If so, who? _____

When? _____ Why? _____

Does your child fall often? ___Yes ___No

Do you consider your child clumsy? ___Yes ___No

Do you have any concerns with the way your child walks, runs or goes up and down stairs? ___Yes ___No

Primary concerns in any of these areas? If so, please describe: _____

_____

_____

_____

Hearing:

Has your child's hearing appeared normal? ___Yes ___No

If no, describe: _____

_____

_____

Does he/she respond to soft or moderate sounds? ___Yes ___No

Does he/she seem to listen to people's voices? ___Yes ___No

Can he/she follow instructions which are expected for his/her age? ___Yes ___No

Does he/she listen to children's stories? ___Yes ___No

SPEECH AND LANGUAGE:

Please provide age and example for the below categories:

Age: Example:

1. Babbling _____
2. First words _____
3. Put 2 words together _____
4. Put 3-4 words together _____
5. Sentences _____

How does the child usually communicate? ___Gestures ___Single Words ____Short Phrases ___Sentences? Please explain: _____

_____

_____

Has the speech progress ever been interrupted or reversed? If so, please describe: _____

_____

_____

When was the problem with speech/language first noticed? _____

_____

_____

Did it follow any illness, accident or unusual occurrence? ___Yes ___No

If so, please describe _____

_____

In your own words, please describe your child's speech/language problem _____

_____

_____

Please give two to three examples of your child's comments that are typical at this time_____

_____

_____

Does the family understand his/her speech most of the time? ___Yes ___No

Do people outside of the family? ___Yes ___No

Does anyone in your family have a history of speech/language difficulties? __Yes ___No

Thank You!