NEURODEVELOPMENTAL THERAPY SERVICES, INC.

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Client Information

Please complete and return to NTS prior to the client's initial evaluation. Thank you.

Client Name: ______________________________ Birthday: ____________________________
Parent/Guardian Name: ______________________ E-Mail Address: ______________________
Home phone: ______________________________ Cell Phone: __________________________
Address: ____
Clinic location interested in: Northwest / West

I. Diagnosis:
Reasons for referral: ____
____

Please list any medical diagnoses: ____
____
____

Please describe any circumstances surrounding the onset of this problem (e.g. illness, from birth)
____
____

Please list any family history of developmental delays, language delays, or mental health issues (e.g. anxiety, OCD, ADHD).
____
____

II. Parent Concerns:
What are the most important issues associated with the client's needs?
____
____
____
____

What are the client's strengths?

____

____

What part of your family's daily routine is most challenging for the client, and why?

____

____

What is calming for the client?

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____

What goals would you like the client to achieve in therapy?

____

____

____

Are you willing to participate in therapy sessions when the therapist feels it is appropriate? Are you willing to use therapy strategies at home when appropriate? If no, why?

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____

Has the client previously received therapy? If yes, please list what type of therapy, where, when, and how often they received services?

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____

Is the client currently receiving any other specialized instruction or services? If yes, where and how often? (i.e. cranial sacral, applied behavior approach, horseback riding)

____

____

III. Birth History:

Please describe any difficulties associated with pregnancy or birth. Include any diagnoses made at birth. ____

____

____

Birth Details (please check all applicable, and add information as needed):

Premature (how many wks)_________	On time _________	Over due _________
Vaginal_________	C-Section_________	NICU (how long) _________
Labor induced (why?)_________	Labor lasted (hrs)_______	Multiple birth_________
Birth weight_________	Birth length_________	Apgar score_________
Jaundice_________	Incubator_________	Intubated (how long)_______
Feeding difficulty_________	Reflux_________	Breast or bottle-fed________

IV. Medical History:
Has the client had any serious illnesses or accidents? If yes, please describe and include any hospitalizations and surgeries.

____

____

Is the client presently taking medications? Please list medication and reason for administration.

____

____

____

Does the client have any allergies? If yes, please describe.

____

____

Is the client on any special diet for nutritional or allergic reasons?

____

____

Has the client ever had a seizure? If yes, please describe and list medications and techniques used to control seizures.

____

____

Has the client's vision been evaluated? When? By whom? ________________________________

Does the client have any visual impairment? If yes, please describe the nature and management of the impairment.

____

____

Has the client had any ear infections? If yes, how many?

____

____

Does the client have tubes in his/her ears? If yes, for how long? When was the last time the tubes were checked?

____

____

Has the child's hearing been evaluated? When? By whom? ________________________________

Does the client have any hearing loss? In one ear or both? What degree of loss is it and what frequencies does it cover? Does the client wear hearing aids or have other devices to help him/her hear? ____

____

Has the client had any nose, throat or palate disorders (i.e.: clefts), procedures (i.e.: video fluoroscopy) or operations (i.e.: tonsils and adenoids removed)? Please describe below including dates. ____

____

Has the client ever had a modified barium swallow study, an upper GI, a pH probe or a gastric motility study? If yes, please give the reasons why, and when the procedure was done, and any results of the procedure.

____

____

V. Developmental History:

1. Language:

What is the primary mode of communication for the client (e.g. words, gestures, signs, pictures, AAC device)?

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How many words does the client say, or tell us if they are using complete sentences. Please give examples of the words/sentences they use.

____

____

What are your concerns about the client's speech sounds? Do you understand the client's words? Do unfamiliar listeners understand the client?

____

____

What languages are spoken to the child? Home__________________ School__________________
Does the client have similar problems communicating in the other language(s)?________ If yes, please describe____

2. Developmental Milestones:

At what age did the client first accomplish the following:

Developmental Skills	Age	Remarks
Rolled over		
Sat alone		
Crawled on hands/knees		
Pulled to stand		
Walked		
Babbled		
Spoke first word		
Combined 2-3 words		
Began eating pureed baby food		
Finger fed		
Self-fed with utensils		

Developmental Skills	Age	Remarks
Used a sippy cup		
Used an un-lidded cup		
Used a straw		
Bladder control		
Bowel control		
Dress self		

3. Motor Skills:

Compared to others of the same age and sex, does the client seem to have difficulty:

Motor Skills	Yes	No	Sometimes	Remarks
Manipulating small objects (i.e., buttons, beads)				
Using pencils, crayons, paint-brushes				
Using scissors				
Catching a ball				
Throwing a ball				
Riding a tricycle (if under age 6)				
Riding a bicycle (if over age 6)				
Pumping self on the swing?				
Kicking a ball				

Compared with others, does the client more often seem to:

Activity	Yes	No	Sometimes	Remarks
Prefer sedentary activities (i.e., watching TV)				
Prefer fine motor activities (i.e., coloring, building with blocks, beading)				
Prefer gross motor activities (i.e., swinging, running)				
Seek out swinging activities				
Trip over or bump into things				
Prefer indoor activities				
Prefer outdoor activities				

Does/did the client participate in tummy time as an infant? If so, for how long each day?

____

Please describe any equipment the client is currently using for mobility, self-care, vision, hearing, communication, positioning or splinting.

____

____

Does the client's home have any stairs?____

Does the client fall often? If so, how many times a day/week? _______________________

4. Feeding/Oral Motor:
Does the client have any oral motor difficulties including feeding, speech, or language?

____

____

Does the client prefer certain foods or liquids including tastes, textures or temperatures?

____

____

Does the client have difficulty with sucking, chewing, using utensils, choking, reflux, swallowing food whole, tooth grinding or drooling?

____

____

VI. Social History:
1. Education:
Name of School/educational program currently attending: ______________________________
Current grade level: ____________________

Please list any Special Education services, therapy services, or behavioral interventions received at school: ____

____

Does the client experience any difficulty in preschool/school? Please describe.

____

____

Compared with others of the same age, does the client:

Academic Performance	Yes	No	Sometimes	Remarks
Have poor handwriting				
Make reversals of letters or numbers when writing or copying (if older than age 7)				
Perform the same tasks with either hand (i.e., writing, eating)				
Seem to tire quickly, have poor posture, or prop his/her head while reading/writing at a desk				
Find gym class or sports to be particularly difficult or frustrating				
Tend to clutter work areas excessively				
Have excessive difficulty switching from active to quiet activities (i.e., playground to seatwork)				

2. <u>Social Adjustment:</u>
Compared with others of the same age, does the client:

Social Skills	Yes	No	Sometimes	Remarks
Find it hard to make friends among his/her peers				
Prefer the company of adults to that of peers				
Prefer to play with younger children rather than peers				
Prefer to play alone				
Frequently get discouraged easily, or express feelings of failure or frustration				
Seem to have less fun when playing				
Frequently express feelings of anger or frustration by hitting or kicking rather than with words				
Frequently throw temper tantrums				
Have difficulty calming himself/herself when upset				
Have difficulty following instructions				
Dislike changes in routines				

Please list any other family members or caregivers (parent, sibling, grandparent, nanny) who routinely look after the client. Include ages of any siblings.

____

____

3. <u>Sleep Habits</u>:
What position does the child sleep in (tummy, back, side)?

____

Describe client's sleep location (e.g. crib, bed, co-sleep). ___________________________________
What time is bedtime? ____
How well does the client transition to bedtime? ____

____

How many hours a night does the client sleep? Any naps?

____

Any difficulties with sleeping? ____

Thank you for taking the time to fill out this questionnaire.
This information will greatly assist the therapist working with the client in meeting his/her needs. Please feel free to make additional comments in the space below.

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