JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

Developmental & Rehabilitation Services

Patient History **Date**: _____

Patient Name:	**Person Completing Form:**	**Relationship to Patient**:

Share your specific concerns and questions for this evaluation:

During Pregnancy

____ Excessive vomiting
____ Hemorrhaging/bleeding
____ X-ray treatment
____ RH incompatibility
____ Drug/alcohol use
____ Medications
____ Trauma/injury
____ Number of miscarriages
____ Other: _____
_____

Labor and Delivery

____ Full term
____ Premature (EGA: _____ or Weeks early: _____)
____ Birth weight: ____ lbs ____ oz
____ Normal delivery
____ Induced
____ Forceps/vacuum
____ Cesarean
____ Breech position
____ Other: _____
_____

Conditions After Birth

____ Low APGARS
____ Breathing difficulties
____ Oxygen: _____ days/weeks
____ Ventilator: _____ days/weeks
____ Sucking/feeding difficulties
____ Seizures
____ Jaundice
____ Bleeding in brain
____ Heart problems
____ Persistent pulmonary hypertension
____ Other: _____

Allergies: _____

Current Medications: _____
_____
_____

Medical History Since Birth

Specific diagnosis(es) or syndromes: _____
_____

____ Chronic colds
____ Multiple ear infections/tubes
____ Tonsillitis and/or tonsils/adenoids removed
____ Asthma
____ Respiratory problems: _____
____ Intubation/ventilation
____ Cleft lip or palate/craniofacial malformation
____ Failure to thrive
____ Heart problems
____ Renal (kidney) problems
____ Gastrointestinal issues: _____
____ Reflux
____ Spina bifida
____ Neurological issues: _____
____ Encephalitis
____ Meningitis
____ Head trauma/brain injury
____ Seizures
____ Autism
____ Cerebral palsy
____ Torticollis
____ ADHD/ADD
____ Learning disability
____ Cognitive delays
____ Juvenile arthritis
____ Surgeries/hospitalizations/injuries: _____
_____
____ Other: _____

Pain Assessment

Is your child currently experiencing pain? ☐ Yes ☐ No
If yes, please describe: _____
_____

Current Equipment

____ Wheelchair ____ Tracheostomy
____ Glasses ____ Hearing aid(s)
____ AFOs ____ Splints
____ Other: _____

Patient ID

Previous/Current Evaluation or Treatment

_____ Physical Therapy _____ Feeding
_____ Occupational Therapy _____ Speech
_____ ABA/Behaviorist _____ Audiology
_____ Developmental _____ Early Steps
_____ Psychoeducational/IQ
_____ Other: _____

If yes to any of the above, give location and dates:

_____
_____
_____

Other physicians/professionals involved in child's care:

_____
_____
_____

Has your child had a recent setback due to hospitalization or medical condition? ☐ Yes ☐ No
If yes, what was their prior level of function? _____

_____
_____
_____

Developmental/Behavioral	**Estimated Age**
Sat alone	_____
Crawled	_____
Stood alone	_____
Walked independently	_____
Bladder trained	_____
Bowel trained	_____
Self-fed with spoon	_____
Assisted with dressing	_____
Cooing, pleasure sounds	_____
Babbling (ba-ba, da-da-da, etc.)	_____
Jargon, jabbering	_____
Single words _____	_____
Phrases (go bye-bye, more juice, etc.)	_____
Short sentences	_____

Education

Day care, preschool, or school child attends: _____

_____

Days/week: _____
Hours/days: _____
Likes school: ☐ Yes ☐ No
Current grade: _____
Ever failed a grade: ☐ Yes ☐ No
Has a teacher expressed concerns about your child's learning or behaviors? ☐ Yes ☐ No
Describe: _____

_____

Family and Pets Residing in Home

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History of Related Problems

_____
_____
_____

Check Behaviors Which Describe Your Child

____ Inattentive; easily distracted
____ Impulsive
____ Excessive activity level
____ Excessive tantrums
____ Aggressive behaviors (Circle all those that apply: hitting, biting, hair pulling, kicking, head-butting, pinching, throwing, spitting, verbal aggression)
____ Defiant, non-compliant
____ Wanders or runs away; elopement
____ Obsessions, compulsions or rituals
____ Destructive behaviors
____ Self-abusive
____ Shy
____ Slow to warm up
____ Outgoing
____ Nervous, anxious
____ Easily controlled/passive
____ Easily annoyed, angered
____ Difficulty handling frustration
____ Frequently irritable, fussy
____ Difficulty calming or soothing self
____ Mood swings/unpredictability
____ Argumentative
____ Difficulty separating from parent
____ Does not interact with caregiver
____ Lack of interest in sharing enjoyment with others
____ Avoids eye contact
____ Difficulty playing with other children
____ Need for sameness and routines
____ Preoccupation with a certain topic
____ Unusual focus on pieces verses whole toy
____ Repetitive play for hours
____ Wanders aimlessly without purposeful play

Favorite toys/activities: _____

_____

Other: _____

Patient ID

Speech-Language

Child primarily communicates with:

____ Gestures ____ Facial expressions
____ Single words ____ Phrases
____ Sentences ____ Conversation

Child's speech is:

____ Easy to understand
____ Difficult to understand by others

Child understands:

____ Family names ____ Names of objects
____ Simple directions ____ Complex directions
____ Conversational speech

Child demonstrates voice problems:

____ Hoarse voice ____ Vocal nodules
____ Sounds like child has cold in nose
____ Talks as if air coming out of nose

Child stutters/describe: _____

Did our child ever stop talking or stop saying words he used to say? ☐ Yes ☐ No

Other: _____

Oral Motor/Feeding

____ Current feeding problems
____ Previous feeding problems

Describe: _____

_____

____ Requires a special diet: _____
____ Takes pacifier
____ Sucks thumb
____ Drools
____ Grinds teeth
____ Breathes through mouth
____ Snores
____ Does not eat age-appropriate food
____ Does not use age-appropriate utensils
____ Does not feed self
____ Problems gaining weight
____ Regularly chokes/gags on food
____ Picky eater/extreme food preferences
____ Refuses to try new foods
____ Sensitive to food smells

Other: _____

Hearing

Evaluated? ☐ Yes ☐ No

Where? _____

When? _____

Results: _____

Not evaluated but have concerns? ☐ Yes ☐ No

Describe: _____

Fine Motor/Visual Motor

Hand Preference: ☐ Right ☐ Left ☐ Both

Writing Grasp: ☐ Functional ☐ Problematic

____ Difficulty drawing lines
____ Difficulty copying shapes
____ Unable to write name by the age of 5
____ Difficulty using "tools" (pencils, silverware, scissors
____ Difficulty grasping or manipulating small items
____ Difficulty with clothing fasteners (i.e. buttons, zippers)
____ Difficulty imitating patterns or block designs
____ Difficulty with precision (placing letters on the line, staying within a maze, etc.)
____ Difficulty with age appropriate puzzles
____ Difficulty with age appropriate matching

Other: _____

Sensory Processing

____ Resists cuddling, pulls away, arches
____ Does not like to wear certain clothing
____ Bothered by clothing tags or seams
____ Dislikes grooming and hygiene activities
____ Startles easily to loud sounds
____ Distracted by sounds not noticed by others
____ Dislikes particular noises or songs: _____
____ Dislikes noisy or crowded environments
____ Sensitive to bright light
____ Dislikes swinging/spinning or playground equipment
____ Craves swinging/moving upside down
____ Difficulty sitting still/in constant motion
____ Takes excessive risks during play
____ Rocking or hand-flapping
____ Uses too much force/breaks objects easily
____ Uses too little force/weak grasp
____ Difficulty falling asleep
____ Difficulty staying asleep
____ Difficulty changing activities/routines

Other: _____

Motor Skills/Body Coordination

____ Unsteady when walking
____ Poor balance: ☐ Sitting ☐ Standing ☐ Both
____ Frequent falls
____ Poor body awareness, clumsy, bumps into things
____ Poor body coordination (i.e. jumping, skipping)
____ Poor eye-hand coordination (catching a ball)
____ Difficulty in PE or on the playground
____ Poor endurance/tires easily
____ Walks on toes

Other: _____

Patient ID