FOCUS ON KIDS TOO, INC.

Pediatric Rehabilitation and Education Centre

425 Huehl Road, Building 14A, Northbrook, IL 60062 (847) 412-9772 Fax (847) 412-9773

Child's name: ______________________ Birth date: ____________ Age: ________

Mother's name: ______________________ Father's name: ______________________

Home address: ______________________ City/State: ______________ Zip: ________

Siblings: ______________________ ______________Pets: ______________________

Home phone: ______________ Cell: ______________ Work: ______________

E-mail address/es:____

Other care givers (nanny, sitters): ____

Please list any medications your child is taking: ____

Please describe the pregnancy: ____

Prenatal History: ____

Treatment received by baby or mother? ____

Postnatal History: ____

Difficulty with: sucking sleeping feeding respiratory distress esophageal reflux

Birth Weight: _______Height: _________Duration of pregnancy: _______ Type of delivery ______________

Apgars: 1 min ______________ 5 mins ______________

Complication(s) at birth:

____

Developmental History:

Please list /describe any important injuries or illnesses including ear and chest infections. At what age did these occur?

____

____

Milestones: At what age did your child:

Turn head to side ________ Sit alone ______Lift head while lying on tummy ________ Crawl-creep __________

Roll over from tummy to back ________ From back to tummy __________Pull to standing ______________

Cruise, walk with support __________ Walk alone ________ Run ________ Climb stairs ______________
______________ Walk down stairs ______________

Feeding: Pureed foods ______________ Table foods ______________ Finger foods __________

Drink from cup ______________ Feed self with spoon ______________

Babble ______________ Say words ______________ Speak in phrases ________

Speak in sentences? ______________ Play with children? ______________

Have you noticed any difference compared to your other children? ______________________

____

____

Do you have any family/living problem which you think might affect your child's development or therapy?

____

What are your child's favorite play activities? ____

____

What type of activities does your child dislike? ____

What school does your child attend? ______________________________________ Grade __________

Does your child have an IEP? Yes No

School Related Services (Please list):

____

What other therapy and/or special education programs has your child had?

____

What other extra curricular activities does your child participate in? (E.g. swimming, gymnastics)

____

Please describe your child's problems?

____

____

____

What would you like us to help your child do? ____

____

____

Does your child use glasses, hearing aid, braces, wheelchair, or other special equipment for daily activities?

____

Are there any allergies, seizures, or other medical problems we should know about?

____

Please check items which your child has difficulty with:

- ability to manage physical requirements of play/school activities
- ability to manage thinking requirements of play/school activities
- self-feeding
- holding/managing feeding utensils
- grooming
- has not learned to do many self-help activities at an age appropriate level
- dressing: has trouble putting on clothes, using buttons, zippers, and laces
- has trouble holding head up while sitting
- becomes easily tired
- when shifting body in chair, sometimes falls out of seat
- stumbles and falls more frequently than others his/her age
- sometimes makes no attempt to catch self when falling
- large movements are clumsy
- has a hard time keeping his/her balance in games, in P.E., on equipment

- is not really good at sports or does not enjoy them
- throwing or catching a ball may be difficult
- walks or runs into furniture, walls
- oversteps or under steps obstacles
- feels heavy or stiff when you try to help him/her position body
- runs in the wrong direction when playing a team sport
- often stands too close to other people
- often bumps into people
- does not stumble or fall, yet wants physical assistance
- becomes anxious when feet leave the ground
- has an unnatural fear of falling or heights
- does not have fun on the playground equipment or with moving toys
- dislikes rough-housing, somersaults, rolling on the floor, jumping
- may avoid climbing, walking on a raised surface, over bumpy ground
- is alarmed if suddenly pushed backward
- is threatened when other people move him/her
- may not allow others to stand nearby when he/she is working
- uses the stair banister more than other children
- does things in an inefficient way
- appears weak, has low muscle tone
- is accident-prone; has many little accidents (spilling milk)
- cannot tolerate upsets in plans and expectations
- complains more about minor physical injuries
- bruises, bumps, and cuts seem to hurt more than they do other children
- is apt to be stubborn or uncooperative
- wants things his/her way
- has a shortage of skills; has to practice each skill over and over
- once a skill is learned, it is performed well
- is slow to learn new games or new motor skills
- eye-hand coordination
- has trouble with pencil control; is messy
- has trouble with cutting, tracing activities
- has trouble pasting a piece of paper on another
- has difficulty reading the writing on the blackboard
- has difficulty copying from the blackboard
- has difficulty spacing letters as he/she writes them
- reverses letters more often than his/her classmates
- sometimes reads words backwards
- does not have normal hand dominance; not skillful with either hand
- sometimes gets right and left confused

- attention span
- hyperactive; distractible, poor attention span
- over stimulates easily
- activity level: extremely active not active
- difficulty with transitions
- toileting
- interacting with family
- interacting with other children
- motivation
- over sensitivities (please circle: touch, sound, taste, smell, movement, light)

Is there anything else you would like us to know at this time that you feel can help us provide better services for your child?
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____

Do we have permission to take photographs of your child for evaluation and student training purposes?

Yes No

May we obtain copies of your child's records from your child's physician or other agencies? If yes, please list below.

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____

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____________________________________ ____________________

Parent/Guardian's Signature Date