GROWING HEALTHY SEASONS℠

Find joy in every moment.

CLIENT INFORMATION AND PERSONAL HISTORY

Today's Date:_____ Completed by:_____

Client's Last Name:_____ First Name:_____

Address: _____ Birthdate:_____Age:_____

City, State, Zip: _____ Gender: _____ Pronouns:_____

Email:_____ Ethnicity:_____

Emergency Contact:_____

name relationship phone

INSURANCE INFORMATION

Client relationship to insured (Circle one): Self ☐ Child☐ Client ID # _____

Primary Insured's Name: (Last, First, MI) _____

Insured's Address: _____

Telephone Number: _____Primary Insured's Date of Birth: _____☐M ☐ F

Employer's Name: _____ Policy Number: _____

Insurance Plan Name or Program: _____

Copayment Amount (if known):_____

Secondary Insurance Information:

Client relationship to insured: _____ Client ID # _____

Insured's Name: (Last, First, MI) _____

Insured's Address: _____

Telephone Number: _____ Insured's Date of Birth: _____ ☐M ☐F

Employer's Name: _____ Policy Number: _____

Insurance Plan Name or Program: _____

FAMILY CONTACT INFORMATION

Mother's Name: _____

Address:_____

_____

Phone (H): _____

Phone (C): _____

Email:_____

Father's Name: _____

Address:_____

_____

Phone (H):_____

Phone (C):_____

Email:_____

FAMILY MEMBERS

		Age	Sex	Adopted	Occupation	Handedness
Father:	_____	___	___	yes☐ no☐	_____	R☐ L☐
Stepfather	_____	___	___	yes☐ no☐	_____	R☐ L☐
Mother	_____	___	___	yes☐ no☐	_____	R☐ L☐
Stepmother	_____	___	___	yes☐ no☐	_____	R☐ L☐
Siblings	_____	___	___	yes☐ no☐	_____	R☐ L☐
	_____	___	___	yes☐ no☐	_____	R☐ L☐
	_____	___	___	yes☐ no☐	_____	R☐ L☐

Marital Status of Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other

Mother's Education:
☐ Less than High School
☐ High School or GED
☐ College
☐ Post College (grad school)

Stepmother's Education
☐ Less than High School
☐ High School or GED
☐ College
☐ Post College (grad school

Father's Education:
☐ Less than High School
☐ High School or GED
☐ College
☐ Post College (grad school)

Stepfather's Education
☐ Less than High School
☐ High School or GED
☐ College
☐ Post College (grad school

FAMILY ADAPTATION

How would you describe your child's general adjustment at home? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

How does your child get along with each member of the family?

Father_____

Stepfather_____

Mother_____

Stepmother_____

Siblings_____

_____

Have there been any traumatic family events in the course of this child's development?

_____
_____
_____
_____

Have there been any major moves? (city to city, country to country)

_____
_____
_____
_____
_____

PERSONALITY PROFILE

What are your child's gifts/strengths? _____ *PROVIDE ANSWERS IN THE LINES BELOW*

_____
_____
_____
_____
_____

What do you enjoy most about your child and family?_____ *PROVIDE ANSWERS IN THE LINES BELOW*

_____
_____
_____
_____

What are the presenting problems for your child? (All categories below may not apply)

Academic:_____
_____

Activities of daily life (eg. eating, dressing): _____
_____

Relationships:_____
_____

Sensory:_____
_____

Motor:_____
_____

Play:_____
_____

Other:_____
_____

What kind of interests and activities does your child have? (hobbies, sports, clubs)
Please list them in order of preference beginning with the favorite activity.

_____
_____
_____

HEALTH PROFILE

Child's Health Care Providers (including Primary Care Physician):

Name:_____Profession:_____Phone:_____

Address:_____

Name:_____Profession:_____Phone:_____

Address:_____

Name:_____Profession:_____Phone:_____

Address:_____

Date of Child's last medical checkup:_____ Height_____ Weight_____

Are there any medical precautions the therapist should be aware of when working with your child?

_____
_____
_____
_____

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

- ☐ ADD
- ☐ ADHD
- ☐ Anxiety Disorder or Mood Disorder (specify):_____
- ☐ Autistic Spectrum Disorder
- ☐ Cognitive Delay
- ☐ Down Syndrome
- ☐ Dyslexia
- ☐ Emotional disorder (specify):_____
- ☐ Fragile X Syndrome
- ☐ Learning Disabilities (specify if possible):_____
- ☐ Sensory Processing Disorder or Sensory Integration Dysfunction
- ☐ Tourette's Syndrome
- ☐ Other (specify):_____

Please note who provided the diagnosis and based on what criteria (i.e., test scores, comprehensive clinical evaluation, genetic study, etc.):_____*PROVIDE ANSWERS IN THE LINES BELOW*_____

_____
_____
_____
_____
_____
_____

MEDICATIONS

List any medications your child has received **in the past**:

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

List any medications your child is **currently** taking:

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

Medication:_____ Purpose:_____ When taken:_____

CHILDHOOD ILLNESSES/PROBLEMS

	Age	Comments/Deficits
☐ ear infections	___	☐None ☐A couple ☐Many _____
☐ tubes in ears	___	_____
☐ respiratory problems	___	_____
☐ high fever	___	_____
☐ meningitis	___	_____
☐ adenoid problems	___	_____
☐ frequent colds	___	_____
☐ strep throat	___	_____
☐ Allergies	If yes, please specify:_____	
	_____	

Check the items below which have been a problem and provide details:

☐ Asthma	_____
☐ Bronchitis	_____
☐ Skin problems	_____
☐ Gastro-Intestinal problems	_____
☐ Seizures	_____
☐ Epilepsy	_____
☐ Nightmares	_____
☐ Sleep	_____
☐ Bedwetting	_____
☐ Nail Biting	_____
☐ Broken limbs	_____
☐ Other	_____

Has he/she ever been hospitalized? Yes☐ No☐
If yes, list reasons:_____
_____

Has he/she ever had a serious accident/injury? Yes☐ No☐
If yes, list accidents:_____
_____

Are there any other medical illnesses or conditions which have been diagnosed?
_____
_____

Is your child in good general health at the present time?_____

PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENTS
Please attach relevant reports.

	ASSESSMENTS			TREATMENTS		
	Yes	No	Place/Date	Yes	No	Place/Date
Medical	☐	☐	_____	☐	☐	_____
Audiological	☐	☐	_____	☐	☐	_____
Speech	☐	☐	_____	☐	☐	_____
Educational	☐	☐	_____	☐	☐	_____
Psychological	☐	☐	_____	☐	☐	_____
Occ. Therapy	☐	☐	_____	☐	☐	_____
Other	☐	☐	_____	☐	☐	_____

Comments:_____
_____
_____
_____

Have there been any specific events or traumas linked with the onset of your child's difficulties?
_____
_____
_____

Is your marital situation stable and positive at this time?_____

What, if any, stresses are affecting your family at this time?_____

PREGNANCY (if child is adopted, please skip to Adopted Section)

What kind of experience was the pregnancy for both mother and father?

Father:_____

Mother:_____

	Yes	No	Comments
Was it planned?	☐	☐	_____
Were there complications?	☐	☐	_____
shock	☐	☐	_____
severe stress	☐	☐	_____
loss of a loved one	☐	☐	_____
accident	☐	☐	_____
health problems, specify	☐	☐	_____
confinement to bed	☐	☐	_____
other	☐	☐	_____
Was mother exposed to loud noises?	☐	☐	_____
Did mother smoke?	☐	☐	_____
Did mother consume alcohol?	☐	☐	_____
Did mother take any medication? specify	☐	☐	_____
Did mother talk much?	☐	☐	_____
Was mother physically active?	☐	☐	_____
Were any previous pregnancies complicated?	☐	☐	_____

LABOR AND DELIVERY

Describe your experience during labor and delivery:_____ *PROVIDE ANSWERS IN THE LINES BELOW*

_____

_____

		Comments
Length of labor?	_____hours	_____
Premature: specify	Yes☐ No☐	_____

		Comments
Forceps used	Yes☐No☐	_____
High forceps required	Yes☐No☐	_____
Suction	Yes☐No☐	_____
Delivery position (ex: breech)	_____	
Caesarean birth (reason)	Yes☐No☐	_____
Birth weight	___lbs___oz	_____
APGAR ratings (if known)	___ ___	_____
Cried immediately	Yes☐No☐	_____
Required special treatment (i.e. required oxygen, had jaundice, etc.)	Yes☐No☐	_____
Birth injuries: specify	Yes☐No☐	_____
Did the newborn have immediate physical contact with the mother?	Yes☐No☐	_____
Was there a positive bonding experience between mother and newborn at birth?	Yes☐No☐	_____

Describe any separations from mother during first days of life:_____

Did mother experience any post-partum depression?	Yes☐No☐	_____

ADOPTION (please skip if child is not adopted)

Describe the circumstances surrounding the adoption: *PROVIDE ANSWERS IN THE LINES BELOW*

_____

_____

_____

More specifically:

Age when adopted:_____

Prior foster homes:_____

Physical appearance:_____

Response to new home:_____

_____

Is your child aware of his/her adoption?_____

INFANCY & TODDLERHOOD

Going back to the first two years of the child's life, what type of baby was he/she? (feeding, sleeping, activity level)

_____
_____
_____
_____
_____
_____
_____

	Yes	No	Comments
Breastfed	☐	☐	_____
Extended separations during first two years (over 3 days)	☐	☐	_____
Specific health problems during this period	☐	☐	_____
Thumb sucking/pacifier (until what age)	☐	☐	_____
Feeding problems	☐	☐	_____
Sleeping problems	☐	☐	_____
Colic or "fussy baby"	☐	☐	_____
Prefer certain positions as an infant (describe)	☐	☐	_____
Dislike lying on stomach	☐	☐	_____
Dislike lying on back	☐	☐	_____
Able to self soothe	☐	☐	_____
On a regular schedule	☐	☐	_____
Enjoy bouncing	☐	☐	_____
Become calmed by car rides or infant swings	☐	☐	_____
Become nauseated by car rides or infant swings	☐	☐	_____
Crawled (at what age)	☐	☐	_____
Toe walker (until what age)	☐	☐	_____
Go through "terrible twos"	☐	☐	_____

Describe your child's toddler stage:_____

_____

DEVELOPMENTAL MILESTONES

(Give approximate ages if remembered, or comment on anything unusual)

Rolling over_____ Walk_____ Say words_____

Sit alone_____ Chew solid food_____ Say sentences_____

Crawl_____Drink from cup_____

Was crawling phase brief? Yes☐ No☐ Absent? Yes☐ No☐

Did child use a walker (rolling plastic seat)? Yes☐ No☐ If yes, how often?_____

Experience hesitancy or delays in learning to go down stairs? Yes☐ No☐

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision?_____

_____

Are there any current problems of which you are aware?_____

_____

When was the last time his/her eyesight was tested?_____

_____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing? (operations, infections, tubes)

_____

_____

Ear infections? seldom☐ sometimes☐ often☐
mild☐ moderate☐ severe☐

Are there any current hearing problems of which you are aware?

_____

_____

SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development?
normal☐ delayed☐ advanced☐

Did your child begin speaking in single words, then two, then a sentence? Yes☐ No☐

Did your child not talk for a long while, then all of a sudden speak in complete sentences? Yes☐ No☐

Do you or others have difficulty understanding what your child says? Yes☐ No☐

First words and at what age:_____

Describe any speech related problems:_____ *PROVIDE ANSWERS IN THE LINES BELOW*

_____

_____

SENSORY AND MOTOR DEVELOPMENT

Please check any that apply:

☐ My child seems to be overly sensitive to sensory experiences more so than most people:
☐ auditory ☐ tactile ☐ visual ☐ movement ☐ taste ☐ smell

☐ My child doesn't seem to react to sensory experiences as readily as most people:
☐ auditory ☐ tactile ☐ visual ☐ movement ☐ taste ☐ smell

☐ My child actively seeks out sensory experiences more so than most people:
☐ auditory ☐ tactile ☐ visual ☐ movement ☐ taste ☐ smell

☐ My child has difficulty differentiating sensory experiences
(ex. confuses sounds, can't find objects in drawer or bag without looking, bumps into things)
Describe:_____

_____

_____

☐ My child has trouble learning new movements.

☐ My child tends to be clumsy and has balance and coordination problems.
Describe:_____

_____

Which language(s) is spoken at home? _____

Are there other individuals or family members living at home? (other than immediate family)

_____

_____

_____

_____

EDUCATION

Current school:_____ Grade in school: _____

Teacher's Name:_____ Type of classroom:_____

How did your child adapt to the first day(s) at school or pre-school:
Mostly positive☐ Mixed☐ Mostly negative☐
How old was he/she?____ How much time did he/she attend per week?_____

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

_____

_____

_____

Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment:_____

_____

Pre-school/Daycare:_____

_____

Primary (K-Gr. 3) :_____

_____

Junior (Gr. 4-6) :_____

_____

Intermediate (Gr. 7-8) _____

_____

High School (Gr. 9-12) _____

_____

Has there been remedial help given **inside** the school system? Yes☐ No☐

If yes, describe:_____

_____

CULTURE, ETHNICITY, IDENTITY

Is there anything about your family's culture that you would like us to be mindful of and/or incorporate into therapy?

_____

_____

Is there anything about your child's ethnicity that you would like us to be mindful of and/or incorporate into therapy?

_____

_____

Is there anything about your child's gender identity or expression that you would like us to be mindful of?

_____

_____

FAMILY'S CLINICAL EXPERIENCES

What kind of experiences have you had with clinicians in the past? What was most helpful to you?

_____

_____

Have you had difficulties with clinicians in the past? What did you find difficult or unhelpful?

_____

_____

Some people prefer clinicians of a similar background (for example, age, race, religion, or some other characteristic) because they think it may be easier to understand each other. Sometimes differences among patients and clinicians make it difficult for them to understand each other. Do you have any concerns about this? If so, in what way?

_____

_____

What families and patients expect from their clinicians is important. As we move forward in your care, how can we best work together?

_____

_____

GOALS

What are your goals for your child's program? Please be as specific as possible.

1._____

_____

_____

2._____

_____

_____

3._____

_____

_____

4._____

_____

_____

5._____

_____

_____

How did you hear about Growing Healthy Seasons? _____