BOLD Pediatric Therapy Center
1815 NW 169th Place, Suite 3070
Beaverton Oregon, 97006
Phone: 971-249-2653
Fax: 503-747-4373

# BOLD Pediatric Therapy Center – Child History Form

Help us get to know your child:

Child's Name: Nickname:

Date of Birth: Today's date:

Form completed by:

Child lives with:

Language(s) spoken at home:

Cultural/ religious preferences you want us to know about: ____________________

## MEDICAL HISTORY

Current medications: ________________________________________________

Are immunizations current? ___ yes ___ no

Allergic to (ie medication, food, environmental): _________________________

Symptoms: ___________________________________________________

Length of pregnancy (in weeks) : _____ Birth weight: _____ Length of hospital stay after birth: _____

Complications during pregnancy: _______________________________________

Prescription/non-prescription drugs taken during pregnancy: _______________

Birth injuries or complications during labor or delivery: ____________________

Describe your child as an infant: _______________________________________

Medical, feeding, or developmental challenges for child as an infant: _________

_____________________________________________________________________

Serious or chronic illnesses, surgeries or hospitalizations that have occurred: _____

_______________________________________________________________________

My child has had: ___ chronic colds ___ difficulty swallowing ___ Tonsillitis ___ Adenoidectomy

___ Tongue structure abnormality ___ jaw structure abnormality ___ cleft palate/lip

___ tongue tie/lip tie ___ ear structure abnormality

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Date of most recent vision test: _____ Results: ___________________________

Wears glasses? ___ yes ___ no

Date of most recent hearing test: _____ Results: ________________________________

History of ear infections? ___ yes ___ no

Have PE tubes been placed? ___ yes ___ no Date(s): _________________

Does your child have regular sleep routines? ___ yes ___ no

Concerns about sleeping pattern: ___________________________________________

## SOCIAL/BEHAVIORAL/ DEVELOPMENT

Describe your child's personality: __________________________________________

______________________________________________________________________

Child attends: ___ day care ___ preschool ___ school ___ other: _________________

History of OR current services in place: ___ OT ___ PT ___ Speech therapy ___ IFSP/ IEP ___ 504

___ developmental pediatrician ___ psych/ counseling services ___ Audiology ___ ENT

___ other specialist (ie Neurology): ________________________________________

Services were received at: ________________________________________________

Dates of services: _______________________________________________________

Does your child have difficulty with: ___ Attention ___ Aggression ____ Frustration Tolerance
___ Following Directions ___ Remembering ___ Transitioning

Child's favorite play activities: ____________________________________________

____________________________________________________________________

How does your child interact with others? __________________________________

What else do you want to tell us about your child? ___________________________
____________________________________________________________________

What do you want to get out of the therapy process?