Shore Kids Pediatric Therapies

14 Bridgewaters Drive, Oceanport, New Jersey, 07757
www.shorekidspedaitrictherapies.com
(732) 460-1500

Child's History:

Child's Name:_____

Date of Birth: _____

Parents' Names:_____

Address:_____

Telephone(Cell):_____work:_____

Email Address: _____

Emergency Contact:_____

Phone number of contact:_____

Referred by:_____

Reason for
Referral:_____
_____

Current School:_____

Current Grade:_____

Medical History

Pediatrician:_____

Telephone:_____

Address:_____

Child's birth weight:_____lbs._____ozs.

Length of pregnancy:_____
_____

Complications during pregnancy and/or delivery? yes/no
If yes, please describe:_____
_____
_____

Pertinent medical, neurological, visual, hearing, therapeutic, psychological or educational testing:

Date of Testing:_____
Diagnosis:_____
_____

Please indicate the following: If you circled yes, please explain.

Seizures-yes or no_____

Chronic Ear Infections: yes or no_____

Hearing Loss: yes or no_____

History of Fevers: yes or no_____

Allergies: yes or no_____

Please describe your child's general health:_____
_____
_____

Any Recent Illnesses: yes or no_____

Has your child received regular immunizations? yes/no

Developmental History: (age approximates)

Lifted head_____rolled over_____
Sat alone_____crawled (on stomach)_____
Pulled to stand_____crept (on hands and knees)_____
Stood alone_____ walked alone_____
Jumped_____ran_____
Finger fed_____towered blocks_____
Used a Spoon/fork_____Used a cup_____
Used a straw_____ Dressed himself_____
Could button or zipper_____Tied shoelaces_____
Colored_____Copied shapes_____
Wrote name_____Cut with scissors_____
Responded to name_____Babbled_____
Spoke First word_____Used 3 or 4 words_____
Toilet trained_____

Has your child been diagnosed with speech and language problems? yes/no
_____

Fine motor problems? yes/no_____

Gross motor problems? yes/no _____

Eating Problems? yes/no_____

Please list any additional information about your child:_____
_____
_____
_____