



Child's Name: _____
Date of Birth: _____

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HISTORY FORM

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

General History

1. Child's Name _____ DOB _____
2. Siblings Names and Ages _____

3. Living Situation and any recent changes _____

4. School History(Name of school(s),IEP,Grade,etc) _____

5. Does your child have any medical diagnoses? Please list _____

6. When did you first become concerned about your child's development?

7. Has your child received occupational, physical, or speech therapy in the past or is he/she currently receiving any of these services? (please list providers)

8. Please indicate at what age each major milestone was reached:
a. Sitting up by self _____ Crawling _____ Walking _____
b. First Word _____ What was their first word? _____

Medical History

1. Did mother have any illnesses or complications during pregnancy or delivery? Please describe _____

2. Was child premature? Yes No
3. Born at how many weeks gestation? _____ Birth Weight _____
4. Did your child require any medical procedures before, during, or after birth? Please describe

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FEEDING

5. Did your child have any feeding problems as an infant? Please describe

6. Was your child bottle fed or breast fed and for how long?

7. Did they have any colic or reflux issues? _____

HEARING

8. Have they had any ear infections? _____

9. Has your child had their hearing tested? What were the results?

ILLNESSES

10. Does your child have any allergies? Please list _____

11. Please describe illnesses, medical issues, or hospitalizations that your child has had and when.

12. Does your child wear glasses or hearing aids? _____

13. *If your child was adopted please answer the following questions:*
14. Age of adoption ____ Is your child aware of adoption? YES NO
15. Previous home experiences _____

Personal Information

1. Please describe your child's personality: _____

2. How do you handle discipline issues at home? _____

3. Does your child have tantrums? YES NO
a. How Often? _____

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4. How does your child handle changes and variation in routine?

5. Please describe your child's eating habits:

6. Please describe your child's sleeping habits/patterns:

7. Briefly describe a typical day for your family, especially this child:
