kaleidoscope PEDIATRIC THERAPY
7211 W Franklin Rd
Boise, ID 83709
P 208-375-4200
F 208-375-4201

Date: _____

Developmental History

Patient Name: _____ Date of Birth _____ ☐ Male ☐ Female

Primary Language Spoken in Home: _____ Other Language Spoken in Home: _____

Any Cultural Influences in the Home or Family? _____

Other Children in the Family: _____

Pregnancy and Birth History

Gestational Age at Birth: _____ Birth Weight: _____

Length of NICU Stay: _____ ☐ Poor suck, swallow, breathe ☐ Colic

Complications during Birth/Pregnancy: _____

Surgeries

Past/Upcoming Surgeries? ☐ Yes ☐ No

Describe: _____

_____

_____

Developmental Milestones

Please note the approximate age your child achieved the following activities:

Rolled:_____ Crawled:_____ Babbled:_____

Put two words together:_____ Sat up alone:_____ Walked:_____

Said first words:_____ Toilet Trained:_____

Current Health

Current medications: _____

Describe your child's health concerns: _____

Describe behavioral concerns: _____

Are there any nutritional or feeding problems? _____

Describe any sensitivities (noise, taste, etc.): _____

Allergies to medications or food: _____

Current Health (cont.)

Check all that apply:

☐ Head injury	☐ Allergies	☐ Thumb/finger sucking	☐ Ear infection/tubes
☐ Constipation	☐ Diarrhea	☐ Oral/speech problems	☐ Swallowing restrictions
☐ Hernia	☐ Asthma	☐ Drug/alcohol exposure	☐ Feeding difficulties
☐ RSV	☐ Surgeries	☐ Heart problems	☐ Stomach problems
☐ Cancer	☐ Diabetes	☐ Depression/anxiety	☐ Skin problems
☐ Hearing Loss	☐ Reflux	☐ Missed milestones	☐ Motor skill issues
☐ Seizures	☐ Vision problems	☐ Sleeping difficulties	☐ Irritable bowel

Please give more details about all areas checked or any other area not listed: _____

_____

_____

_____

Therapy History

Did patient receive early intervention services? ☐ Yes ☐ No

If yes, indicate type of services and duration: _____

_____

Did patient receive any services in an out-patient / clinic setting in the previous year? ☐ Yes ☐ No

If yes, indicate type of therapy and location: _____

_____

Other Professional Working With Child

Optometrist/Ophthalmologist: _____

ENT-Otolaryngologists: _____

Neurologist: _____

Physiatrist: _____

Orthotist/Prosthetist: _____

Orthopedic Physician: _____

Care Coordinator/Service Coordinator: _____

Other: _____

Family Goals with Therapy

Parent Concerns: _____

_____

Goals for Therapy: _____

_____