

Children's Learning Connection

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CHILD INFORMATION

Today's date: _____

Child's name _____ Age _____ Birthdate _____

Parent's names _____

Full Address _____

Home Phone _____

Work phones (list for all caregivers) _____

Cell phones (list for all caregivers) _____

Email _____ Fax _____

Insurance provider _____ PPO/HMO (please circle one)

If HMO, name of medical group _____

Person who referred you _____

Reason for referral (what is your primary concern?) _____

Pediatrician Name _____ Phone Number _____

Has your child been seen by a neurologist? _____

Does your child have any diagnosis? _____

Diagnosing Physician/Agency _____

Age at diagnosis _____

Recommendations made _____

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MEDICAL HISTORY

Birth Weight _____ Premature/Full Term _____

Unusual pregnancy or birth complications _____

Did your child receive any additional medical attention in the hospital after birth? _____

How many hours does your child sleep at night: Duration _____ Start/End Time _____

How many hours does your child nap: Duration _____ Start/End Time _____

Does your child have any difficulty going to sleep? _____

Does your child have difficulty staying asleep? _____

Are there any other factors interrupting your child's sleep? (If yes, please explain) _____

Illnesses (ages, degree of severity, complications, operations) _____

Ear infections (include age, dates, number of episodes, severity) _____

Antibiotics _____ Tubes _____

Date hearing tested _____ Tests used _____

Results _____

Dietary Interventions/Special diets (please describe current and past) _____

Allergies (please describe type and treatment) _____

Medications (please describe current and past) _____

Other medical treatments _____

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FAMILY HISTORY

Mother's Occupation _____

Father's Occupation _____

Siblings (names and ages) _____

Other caregivers involved in your child's life _____

Languages spoken in the home _____

Family history of speech/language problems, learning disabilities, ADD/ADHD, or Autistic Spectrum Disorder _____

DEVELOPMENTAL HISTORY

Feeding History

Nursed/Formula? _____ How long _____

Bottle _____ How long _____

When did your child start eating solid foods? _____

Feeding difficulties (sucking, swallowing, fussy, textured food, vomiting) _____

Pacifier: How long _____ Type _____

When does your child use a pacifier? _____

Does your child currently or has your child ever displayed any of the following behaviors?
(If yes, please age and/or situation this behavior took place.)

Eating problems _____ Drooling _____ Thumb sucking _____

Chewing on objects _____ Overactive gag reflex _____

Does your child independently use a fork or spoon? _____

What type of cup does your child use? _____

Please list the foods your child currently eats _____

What types of foods will your child **not** eat? _____

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Motor Development

At what age did your child sit up _____ roll _____ crawl _____
stand _____ walk _____

What are your child's favorite motor activities (e.g., ball play, swings, slides, coloring)?

Please rate your child's motor skills:

	Poor	Fair	Excellent
Balance	_____	_____	_____
Physical abilities (running, jumping, climbing)	_____	_____	_____
Manual skills (crayons, buttons)	_____	_____	_____
Physical Endurance (running, outside play)	_____	_____	_____

Does your child seek out physical activities? _____ If yes, please explain (e.g., rough housing, crashing into furniture) _____

Does your child avoid physical activities? _____ If yes, please explain _____

Does your child appear stiff and rigid? _____

Does your child appear loose and floppy? _____

Other pertinent information _____

Communication Development

Did your baby babble? _____ Did your toddler use gestures? _____

At what age did your child first use words _____

At what age did she/he produce two-word combinations _____

When was a problem first noticed (please describe) _____

Did your child begin to develop, then lose speech or language skills? _____

Approximate age this occurred _____

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Level of child's abilities before regression _____

Speech-Language Diagnosis? (apraxia, Semantic-Pragmatic Disorder, receptive/expressive language disorder, etc.) _____

Describe child's communication skills now:

Primary means of communication (gestures, Picture Exchange Communication System, sign, speech) _____

Does your child vocalize (make sounds)? _____ What kinds of sounds does your child make? _____

Is your child verbal (uses words)? _____ What kinds of words does your child use? _____

Approximate length of phrases _____

Echolalia (Automatic repetition of words/sounds made by other people)? _____

Effectiveness/frustration with communication _____

Use of gestures _____

Communication Development

Spontaneous communication (producing language without being asked a question)

Do you have difficulty understanding your child's speech? _____

Do other people have difficulty understanding your child's speech? _____

Social-Behavioral History

How would you describe your child's personality _____

How would you describe your child's play _____

Favorite play activities and interests _____

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Does your child play with other children (please describe)? _____

Does your child behave well in public places (please describe)? _____

How many hours of T.V. does your child watch each day? _____

Any of the following:

Aggression _____ Temper tantrums _____ Anxiety _____

Impulsiveness _____ Distractibility _____ Hyperactivity _____

Difficulty controlling emotions _____

Self-stimulatory behaviors (hand flapping, lining up objects, twirling) _____

Social-Behavioral History

Repetitive vocal/verbal behaviors _____

Rituals/routines _____

Toilet training: Bladder _____ Bowel _____

Any other pertinent information regarding your child's behavior _____

TREATMENT AND EDUCATIONAL HISTORY

Is your child currently receiving any treatment services, or has your child received treatment services in the past (please describe, list any agencies, names of therapists, level of service, dates treatments began and ended, and reasons for termination of services)

What setting has your child received treatment in (home, school, clinic) _____

What was productive or not productive for your child in past therapies? _____

Does your child attend school? _____ Where? _____

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Classroom type _____ Days per week/length of stay _____

Teacher _____ Shadow/aide _____

**Please attach a copy of your child's current schedule (include school, nap, current therapies, etc.) or write a schedule below.