Client Information

Please complete the following information so that your therapist has a thorough understanding of how to best work with your child. If there is anything that isn't addressed in this packet but that you think is relevant, please feel free to include it.

Client Name: ____ Date of Birth: __________________

Your Name: ____________________________________ Relationship to Client: ___________________

What prompted you to schedule an appointment at this time?

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Please list any formal diagnoses that your child has: ____

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Please list all your current medications or nutritional supplements (if any)
(Please use other side if necessary.)

Medication or Supplement Name	Dosage and Frequency (e.g., 50 mg 2x/day)	Purpose and Side effects (if any)

CLIENT LIST OF CONCERNS

Client Name: ________________________________ **Date of Birth: ________________**

Please check anything which **might** apply, and put **two checks** against anything which is especially important. Please use the back of this page if more explanation is necessary.

Memory

- ☐ Short Term Memory loss
- ☐ Long Term Memory loss
- ☐ Blocking on words
- ☐ Trouble remembering directions
- ☐ Trouble remembering months of the year
- ☐ Trouble remembering names
- ☐ Trouble remembering right/left
- ☐ Trouble remembering times tables
- ☐ Other: ____________________________

Sensory Processing Difficulties

- ☐ Difficulty following directions
- ☐ Difficulty giving directions
- ☐ Difficulty telling time
- ☐ Difficulty budgeting time
- ☐ Poor eye-hand co-ordination
- ☐ Trouble differentiating colors

Overly sensitive to sensory stimuli:

- ☐ Bothered by noises
- ☐ Bothered by touch
- ☐ Bothered by visual stimuli
- ☐ Bothered by smells

Under sensitive to sensory stimuli:

- ☐ Not hearing others when name is called
- ☐ Frequently bumping into objects or others
- ☐ Other: ____________________________

Speech

- ☐ Difficulty speaking
- ☐ Speech difficulties (explain)

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School/Learning

- ☐ Difficulty completing schoolwork
- ☐ Leaves projects incomplete
- ☐ Getting into trouble at school
- ☐ Difficulty staying in seat
- ☐ Spatial problems (e.g. difficulty building things, understanding how things should be put together)
- ☐ Letter/number reversal
- ☐ Rests head on arm while working
- ☐ Poor handwriting
- ☐ Poor organizational skills
- ☐ Poor reading comprehension
- ☐ Poor reading skills
- ☐ Poor spelling
- ☐ Poor arithmetic
- ☐ Difficulty with particular subjects (explain):

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Attention and Organization

- ☐ Difficulty focusing
- ☐ Easily distracted
- ☐ Make mistakes
- ☐ Difficulty organizing activities
- ☐ Slow in completing work
- ☐ Not completing tasks
- ☐ Loses train of thought
- ☐ Short attention span
- ☐ Stops in the middle of a game
- ☐ Daydreams excessively
- ☐ Inappropriate drowsiness
- ☐ A feeling of "Foggy Brain"
- ☐ Other: __________________________

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Heart/Lungs
- ☐ Problems breathing
- ☐ Heart problems
- ☐ Hypertension
- ☐ Palpitations
- ☐ Dizziness
- ☐ Other: ____________________________

Intestines
- ☐ Nausea or vomiting
- ☐ Gastric pain
- ☐ Gas or bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other: ____________________________

Bowel/Bladder
- ☐ Difficulty urinating
- ☐ Difficulty holding urine
- ☐ Frequent bladder infections
- ☐ Difficulty controlling bowels
- ☐ Difficulty recognizing bowel & bladder sensations
- ☐ Bedwetting
- ☐ Not "Potty" trained
- ☐ Other: ____________________________

Sleep
- ☐ Difficulty falling asleep
- ☐ Wakeful or restless during night
- ☐ Waking up early
- ☐ Difficulty waking up
- ☐ Nightmares or night terrors
- ☐ Snoring
- ☐ Sleep walking
- ☐ Other: ____________________________

Nervous System
- ☐ Headaches or migraines
- ☐ Fainting
- ☐ Seizures
- ☐ Tremor (shaking)
- ☐ Weakness
- ☐ Motor or vocal tics
- ☐ Trouble differentiating hot and cold
- ☐ Not registering/feeling pain - high vs. low pain threshold
- ☐ Vertigo
- ☐ Other: ____________________________

Ear/Nose/Throat/Mouth/Jaw
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Sense of smell changed or lost
- ☐ Nose or sinuses blocked
- ☐ Teeth grinding
- ☐ Sense of taste changed or lost
- ☐ Hoarseness or sore throat
- ☐ Other: ____________________________

Hormonal/Blood
- ☐ Sensitivity to heat or cold
- ☐ Lack of sensitivity to heat or cold - not dressing appropriately for weather
- ☐ Thyroid problems
- ☐ PMS symptoms
- ☐ Hot flashes
- ☐ Other menopausal symptoms
- ☐ Low interest in sex
- ☐ Excessive interest in sex
- ☐ Other: ____________________________

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Movement

- ☐ Accident prone
- ☐ Clumsy
- ☐ General uncoordinated
- ☐ Poor at sports or rhythmic activities
- ☐ Poor balance
- ☐ Poor body awareness
- ☐ Not living in the body
- ☐ Poor motor planning-difficulty with a series of movement (example: sequential dance steps)
- ☐ Other(s)______________________________

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Emotions

- ☐ Mood swings
- ☐ Feeling down, depressed or flat
- ☐ Feeling sad
- ☐ Feeling angry a lot
- ☐ Feeling anxious
- ☐ Panic attacks
- ☐ Worry
- ☐ Feeling hopeless
- ☐ Feeling stuck
- ☐ Feeling overwhelmed
- ☐ Thoughts that won't leave your mind
- ☐ Thoughts are focused on the fear of the future And/or dwelling in the past
- ☐ Over-reactivity to what people say and do
- ☐ Other phobias or fears (explain)

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Cognitive

- ☐ Becoming upset when plans change
- ☐ Becoming upset when having to stop and start new activity (difficulty making transitions)
- ☐ Other(s)______________________________

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Behavior

- ☐ Need to repeat actions or words over and over.
- ☐ Behaviors that get you into trouble, or are not good for you
- ☐ Impulsive
- ☐ Timid/shy
- ☐ Self-injurious behaviors
- ☐ Risk-taking
- ☐ Impatient /restless
- ☐ Lying
- ☐ Controlling
- ☐ Feeling aggressive
- ☐ Actual physical aggression
- ☐ Unable to apologize
- ☐ Other(s)______________________________

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Social Relations

- ☐ Feeling others are against you
- ☐ Test or performance anxiety
- ☐ Social anxiety
- ☐ Fear of speaking in front of people
- ☐ Eye contact avoidance/discomfort
- ☐ Other(s)______________________________

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Energy Level

- ☐ Over or under active
- ☐ Hyperactivity
- ☐ Lethargic
- ☐ Sleepiness
- ☐ Fatigue
- ☐ Other(s)______________________________

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Bones/Joints/Muscles

- ☐ Pain or stiffness in joints or muscles
- ☐ Sore trigger points
- ☐ Bodily fatigue
- ☐ Other:

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Client Information

Lifestyle

Food Habits

- ☐ Eats a healthy diet
- ☐ Appetite problems (e.g. wanting to eat when not hungry, etc)
- ☐ Desire for sweets or carbohydrates
- ☐ Bingeing
- ☐ Restricting your food intake
- ☐ Purging food
- ☐ Other: (Explain) ____________________

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Recreational Drug Use

- ☐ Sometimes drink too much
- ☐ Smoke cigarettes ____________packs a day
- ☐ Caffeine
  - # of cups of coffee a day ____________
  - # of bottles of soda a day ____________
  - # of energy drinks a day____________
- ☐ Marijuana use______________frequency
- ☐ Other illicit drugs (Explain)______________

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Self Care Practices

- ☐ Exercise (Describe) ____________________

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- ☐ Relaxation activities (Describe) __________

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- ☐ Other habits (Describe) ________________

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Self Concept

- ☐ Lacks confidence
- ☐ Has insight into own thoughts & feelings
- ☐ Has insight into others' thoughts & feelings
- ☐ Other: (Explain)

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Eyes

- ☐ Double or blurred vision
- ☐ Blind spots
- ☐ Spots in your vision
- ☐ Difficulty focusing eyes
- ☐ Eye strain / rubs eyes a lot
- ☐ Other:

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Medical History

Client Name: ___________________________________ Date of Birth: _________________

Many of the following questions have to do with your child's first five years of life. If your child is adopted or a foster child who has a living mother with whom you are on good terms, it is often easiest to ask the biological mother. If this is not an option, please don't stress about this form. If you have heard stories about the child, these might help with some of the questions. If not, please put "DK" for "don't know." If you need more space to explain please continue on the back of this sheet and put an arrow indicating that there is more information on the other side.

PREGNANCY

1. Circumstances of the pregnancy: Was the pregnancy planned? Is the child adopted? Is the child a foster child? Describe:

2. Any sickness or accidents during pregnancy? Describe:

3. Any events requiring medical attention during pregnancy? Describe:

4. Any drugs taken during pregnancy, prescribed or not (including cigarettes)? Describe:

BIRTHING CONDITIONS

5. How long was labor?

6. Any drugs used during labor?

7. Cesarean Section?

8. Any difficulties during the birthing process? (For example: cord wrapped around neck, fetal distress, use of forceps)

9. Oxygen problems at birth, baby bluish or had cord been wrapped around neck?

NEONATAL CONDITIONS

10. Was there a period of extended separation? (e.g. premature, and taken away)

Client Information

11. Time spent in an incubator? If yes, why and how long?

12. Any other problems?

13. Breast-fed? If so, for how long?

CHILDHOOD DEVELOPMENT

14. Began crawling when?

15. Crawled normally, that is, opposite hand and knee, or tended to scoot along with bottom, or drag/extend one leg?

16. Crawled for how long?

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17. Went from sitting or holding on to things to walking with little crawling?

18. Started talking at age? Was there any verbal language delay? If so, how long?

19. Fluid in the inner ears? If so, were tubes required?

20. Asthma? If so, medication taken for it? How often?

ALLERGIES

21. Any allergies that you are aware of?

22. Are you allergic to pollen, house dust, house dust mites? If so, which ones?

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23. Allergies to food colorings, dyes or preservatives? If so, which ones?

24. Allergies to chemicals, e.g. gasoline fumes, perfumes, cigarette smoke? If so, which ones?

25. Allergies or intolerances to foods? If so, which ones?
(Symptoms include: feeling tired or hyper-active after eating)

26. Other serious childhood diseases, any operations, or other medical problems?

Childhood Disease or Operation	Age	Medication (if any)

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HEAD OR NECK INJURIES

27. Any serious falls which included hitting the head?

28. Knocked unconscious? If so, for how long and under what circumstances?

29. Whiplash? If yes, please describe the circumstances.

30. Suffered a seizure induced by high temperature or had an epileptic fit?

31. Are there any other things about childhood (or life since) that you think might be relevant? Especially childhood traumas, including divorce, death of parent, abuse, etc.? (Continue on back page if necessary...)