Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

Policies & Procedures

- All co-pays and balances are due at the time of service and must be paid in full before your child will be seen by his/her therapist
- Authorization is **not a guarantee of payment**. If your insurance company denies payment you will be responsible for the entire balance.
- Outstanding balances will be sent to collections and therapy will be discontinued
- 24 hour **CANCELLATION NOTICE** is appreciated; otherwise, there will be a $25 charge
- 2 **NO CALL/NO SHOWS** will forfeit your standing appointment time
- 2 **CANCELLATIONS** must be made up within the following 2 weeks; otherwise, this will result in a forfeiture of your standing appointment time
- Returned checks will result in a $25 fee due at the time of notification
- We are a **teaching facility;** therefore, there may be times when a student observes or runs the therapy session under the supervision of the treating therapist. You will be notified before the session begins if a student will be involved in the therapy session.
- Due to insurance liabilities we ask that you be seated in the waiting area until a therapist can lead your child to a treatment room for therapy
- If you choose to bring siblings with you, please bring activities to keep them occupied as excessive volume may interrupt treatment sessions. Siblings are not allowed on therapy equipment at any time
- Please note that your therapist may advise you to step out of the therapy session or remain in the waiting room during the therapy session to ensure your child's optimal performance and to establish a trusting relationship and good rapport with your child.
- We do our very best to begin and end treatment sessions on time. Please be prompt for appointments as they end 40 minutes from the start of your scheduled appointment time. If you choose to drop off your child for therapy, please leave an emergency contact number at the front desk and return to the waiting room before your child's session is over.
- If your child is potty training or was recently potty trained, please bring extra diapers and a change of clothes
- We reserve the right to discontinue therapy services if we feel our staff, other patients, and/or your child are at risk for injury or physical harm due to **aggressive behaviors** before, during, and/or after therapy sessions. When appropriate, we will offer a one-time warning before discontinuing services. Aggressive behaviors include, but are not limited to, hitting, kicking, biting, punching, shoving, hair pulling, inappropriate language, and destruction of property.
- Unless we are provided with legal documents stating otherwise, we are required by law to provide both parents with information regarding the child's therapy services, progress, etc.

By signing this document, I acknowledge that I have read and agree to everything listed in the above policy and procedures.

Signature_____Date_____

Corporate Office
10560 Old Olive St. Rd., Suite 100
Creve Coeur, MO 63141
314.567.4707 314.567.4505 - fax

St. Peters Office
4200 N. Cloverleaf, Suite J
St. Peters, MO 63376
636.922.4700 636.922.4505 - fax

www.sensorysolutions.org

Sensory Solutions, LLC
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CLIENT FINANCIAL RESPONSIBILITY & CANCELLATION POLICY

It is important to discuss with our clients our financial policy so we may provide the best services for your child. Sensory Solutions, LLC is one of the only private therapy companies that allow families to bill services through their insurance. In taking on this additional responsibility, it is critical that families do their part to ensure that the services being provided for their child are being paid and therapists time being respected.

Deductibles need to be met at the beginning of each fiscal year by major insurance companies. Families are responsible for paying their deductible up front. Families need to pay all deductible payments and co/pays prior to the beginning of their child's therapy session. All bills must be paid prior to each therapy session. If bills become delinquent, therapy will be terminated immediately. If payment is not received, the case will be turned over to our company attorney for collections.

We allow "standing" appointments to our clients to assist with your schedule and ours. In doing this, we will respect your appointment time and will ensure that a therapist will be available if your particular therapist is sick or on vacation. To reciprocate that respect, we ask that you be 5 minutes early to your appointments. If you are late, it takes from your child's session. Each session is 40 minutes in duration so please try and arrive on time. We also ask that you respect our cancellation policy. We are here each and every day to provide a service and need your child here in order to treat him/her and make the most progress possible. It is our experience that children progress toward their therapy goals when there is consistent attendance.

CANCELLATION/ MAKE UP POLICY:

For clients being seen once per week, there will be TWO allowed cancellations per year. For clients being seen twice per week, there will be FOUR allowed. Any other cancellations are subject to our make- up policy. You will be billed (not insurance) for the cancelled session at the rate your insurance company reimburses. You will be allowed to make up this visit and will be credited the amount paid. You will not be reimbursed until the end of your make up session. If you know in advance you will be missing certain sessions (winter break, spring break, vacation) please try to schedule those make up sessions in advance. In case of long-term injury or illness, cases will be dealt with on an individual basis. Cancellations for days the clinic is closed will not be billed.
This policy includes those that are scheduled for a group session as well.

NO SHOWS:

If you have not canceled a regularly scheduled appointment or scheduled a make-up session and still do not come, you are considered a "no show" and you will be billed for your session. "No show" sessions are not subject to our make-up policy

Name: _____ Date: _____

Sensory Solutions, LLC
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CONFIDENTIALITY POLICY

At Sensory Solutions, LLC we are committed to maintaining client confidentiality. However, due to space constraints, we are unable to meet with each of our clients families in a private area at the end of each session. Therefore, we use the waiting area to provide you with information about your child's therapy session and home recommendations. We understand that you may prefer an alternative arrangement. If so, please let us know and we will accommodate you. If you prefer, you can schedule a meeting or phone consult with your child's therapist every 1-2 months in place of one of your child's sessions or in addition to his/ her session. Please understand that this visit will be billed privately to the family, not billed through insurance.

Child's name: _____

Parent's name: _____

_____ I DO GIVE permission for my child's therapist at Sensory Solutions, LLC to discuss and share verbal and/or written information about my child in the public waiting room at the end of each session.

_____ I DO NOT GIVE permission for my child's therapist at Sensory Solutions, LLC to discuss and share verbal and/ or written information about my child in the public waiting room at the end of each session. I will schedule a meeting or phone consult with my child's therapist every 1-2 months to discuss my child's therapy sessions. I understand that I will be billed for this meeting and that I may schedule this in lieu of a session. This will be billed as a private visit, not an insurance visit.

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EMERGENCY CONTACT:

Child: _____ Birthdate:_____ Phone: (__)_____

Address: _____ Zip: _____ Email: _____

Parent Name (1)_____ Cell: _____

Parent Name (2) _____ Cell: _____

Caregiver's Name_____ Cell:_____

Two people we can reach in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship:_____ Phone:_____

Conditions that might require Immediate or Emergency Care
(Diabetes, food allergies, epilepsy, etc.)

1. _____ Treatment _____

2. _____ Treatment_____

I accept responsibility for any necessary expense incurred in the medical treatment of my child which is not covered by the following:

Insurance co. _____ Policy No._____

Parent's signature: _____ Date _____

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Sensory Solutions, LLC
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Patient History Form

***Please fill out the questionnaire as accurately and completely as possible.**

Child's Name:_____ Birthdate:_____
Referred by:_____
What are your concerns regarding your child?_____
_____
_____

Mother's Name:_____
Address:_____
Zip Code:_____ Cell Phone:_____ Home Phone:_____
Email:_____
Education:_____ Occupation:_____
Employer:_____ Work Phone:_____

Father's Name:_____
Address_____
Zip Code:_____ Cell Phone:_____ Home Phone:_____
Email:_____
Education:_____ Occupation:_____
Employer:_____ Work Phone:_____

Siblings (and ages):_____

Marital Status (Please check): __ Married __ Separated __ Divorced __ Widowed __ Single

Medical Insurance Company:_____
Whom will be responsible for payments:_____

Emergency contact information:
Name:_____ Relationship:_____
Phone Number:_____

Child's Pediatrician:_____
Address:_____
Zip Code:_____ Phone:_____ Fax:_____
How long has your child been under this physician's care?:_____

MEDICAL HISTORY:

Pregnancy: ___ Full Term ___Premature
Length of Pregnancy:_____
Mother's general health during pregnancy: ____ Good ____Fair ____Poor
Problems encountered during pregnancy (e.g., illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.):_____
_____
_____

Length of total labor:_____ Difficult labor: __ Yes __No
Delivery Type:
__Vaginal
__C-section

Complications:
__Induced Birth
__Breech Presentation
__Limpness
__Stiffness
__Other:_____
Elaborate on above delivery complications:_____
_____
_____
_____

Length of hospitalization:_____ Child's birth weight: _____lbs. _____oz.
Complications:
__Jaundice
__Cyanosis
__Congenital defects
__Other:_____

Was there a need for:
__Oxygen
__Transfusions
__Tube Feedings
If so, please explain:_____
_____

Were there any feeding difficulties at birth: __Yes __No
Explain:_____
_____

Problems encountered during your child's first month:_____
_____

List illnesses/diseases your child has experienced:
Illness:_____ Age:_____
Illness:_____ Age:_____
Illness:_____ Age:_____

List injuries/operations your child has had:
Injury/operation:_____ Age:_____
Injury/operation:_____ Age:_____
Injury/operation:_____ Age:_____

Has your child experienced high fevers: __Yes __No
Age:_____ Temp:_____ Frequency:_____

Has your child experienced convulsions/seizures: __Yes __No
Age:_____ Type:_____ Frequency:_____ Medication:_____

Has your child experienced ear infections: __Yes __No Frequency:_____
Has your child had tubes placed: __Yes __No When:_____

Date of last hearing evaluation:_____ Results:_____
Where was the hearing evaluation completed:_____

Date of last vision evaluation:_____ Results:_____
Where was the vision evaluation completed:_____

Allergies:
__None
__Seasonal
__Food
__Other
Please list all allergies:_____
_____

History of acid reflux: ____Yes ____No
If yes, when and how was it treated:_____

Child's general health at present:
__Good
__Fair
__Poor

Sensory Solutions, LLC
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Is your child currently taking any medications: __Yes __No
If yes, type(s):_____
_____

SPECIALTY CONTACTS:

Specialty	**Name of Agency/Specialist**	**Address**	**Phone**
Audiologist			
Behavior Therapist			
Cardiologist			
Chiropractor			
ENT			
Occupational Therapist			
Opthamologist/ Optometrist			
Orthopedist			
Physical Therapist			
Psychologist/ Psychiatrist			
Speech Pathologist			
GI			
Other			

Sensory Solutions, LLC
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DEVELOPMENTAL HISTORY:

Check which of the following describes/described your child as an infant:
__Fussy
__Irritable
__Good
__Quiet
__Passive
__Active
__Liked being held
__Resisted being held
__Floppy when held
__Tense muscles when held
__Good sleep patterns
__Irregular sleep patterns

Check which of the following describes your child at present:
__Usually happy
__Mostly quiet
__Overly active
__Tires easily
__Talks constantly
__Too impulsive
__Restless
__Resistant to changes
__Clumsy
__Fights frequently
__Difficulty separating from primary caretakers
__Falls often
__Poor attention span
__Easily frustrated
__Cries often
__Cries infrequently
__Rocks self frequently
__Has difficulty learning new tasks
__Stubborn
__Overreacts
__Wets bed
__Frequent temper tantrums
__Nervous habits or tics

Approximate ages in which your child completed the following routinely:
Held up head (while on stomach):_____
Rolled over:_____
Belly crawled:_____
Crawled on hands and knees:_____
Sat independently:_____
Pulled to standing:_____
Standing independently:_____
Walking independently:_____
Babbling:_____ Were there a variety of sounds:_____
Producing single words:_____
Combining 2-words:_____
Obeying simple commands:_____

Does your child wear orthotics: __Yes __No Type:_____
Does your child require/use medical equipment:_____
Does your child use assistive devices for walking: __Yes __No Type:_____

General impressions of your child's motor development:
Gross Motor: __Slow __Normal __Advanced
Fine Motor: __Slow __Normal __Advanced
Handwriting: __Poor __Fair __Good

Does your child show a hand preference with:
__Feeding Which hand:_____
__Writing/Drawing Which hand:_____
__Throwing Which hand:_____
__Pointing Which hand:_____
__Cutting Which hand:_____

Has your child achieved skills and then lost them: __Yes __No
Explain (what and when):_____
_____

Has your child received prior therapy? (Please check all that apply):
___ First Steps ___ School ___ Outpatient facility similar to Sensory Solutions

FEEDING:
Bottle fed: __Yes __No Type of formula:_____
Nursed: __Yes __No

Currently eats:
__Breast milk
__Formula
__Baby food
__Junior foods
__Mashed table foods
__Table foods

Feeds self: __All __Most __Some __Rare

If feeds self, uses: __Bottle __Fingers __Spoon __Fork

Drinks from:
__Bottle __Sippy cup __Soft straw __Hard straw __Open cup

List most preferred foods:_____

_____
_____

List avoided foods:_____
_____
_____

SELF-CARE:
Bathes self: __All __Most __Some __None
Undresses self: __All __Most __Some __None
Dresses self: __All __Most __Some __None

Is your child toilet trained: __Yes __No
If yes, at what age:_____
__Bladder (daytime) __Bladder (day and nighttime) __Bowel

SENSORY HISTORY:

VESTIBULAR (Movement and gravity information). Check all that apply:
__Rocks while sitting
__Likes being tossed in the air
__Fearful of heights
__Likes Merry-Go-Rounds
__Gets car sick
__Enjoys being rocked: __Now __As an infant
__No fear of movement or falling
__Jumps a lot
__Good balance
__Fearful of movement
__Spins and Whirls more than others
__Prefers quiet play as opposed to active
Comments:_____
_____

TACTILE (Touch information). Check all that apply:
__Avoids messy things (mud, finger paints, etc.)
__Irritated by cloth of certain textures
__Dislikes unexpected touch
__Bangs head on purpose (now or in past)
__Mouths non-food objects
__Isolates self from others
__Excessively ticklish
__Dislikes nail cutting
__Seeks a lot of touch
__Dislikes face or hands washed
__Objects to being touched
__Avoids using hands for extended periods
__Pinches, bites, hurts self
__Feels pain less than others
__Strong like/dislike toward food textures
__Dislikes hair washing
__Wants to handle everything
Comments:_____
_____

PROPRIOCEPTIVE (Muscle and joint information). Check all that apply:

__Holds hands in strange positions
__Holds body in strange positions
__Good coordination with small items
__Walks on toes (or did when younger)
__Went from sitting to standing with little to no crawling
__Crept on tummy rather than hands and knees
__Leaps from one position to the next, unable to move slowly from one place to another

Comments:_____
_____

AUDITORY: (Check all that apply)

__Responds negatively to unexpected or loud noise
__Has difficulty paying attention when there are other noises nearby
__Misses hearing some sounds
__Seems confused as to the direction of sounds
__Seems to enjoy strange noises and/or makes loud noises
__Appears to be hard of hearing
__Enjoys music
__Has a diagnosed hearing loss
__Wears a hearing aid

Comments:_____
_____

VISUAL: (Check all that apply)

__Reversals in copying
__Happier in the dark
__Looks very closely at pictures/objects
__Difficulty discriminating shapes or colors
__Resists having eyes covered
__Squints often
__Becomes excited when there is a variety of visual objects
__Difficulty focusing on objects far away
__Difficulty focusing on close objects
__Wears glasses
__Difficulty maintaining eye contact
__Difficulty following objects across the room
__Sometimes shakes head awkwardly
__Difficulty following object tossed to him/her
__Shifts head to one side in order to look at an object

Comments:_____
_____

GUSTATORY-OLFACTORY (Taste and smell information). Check all that apply:

__Acts as though all food tastes the same
__Chews on non-food objects
__Has unusual cravings for certain foods
__Dislikes food of certain textures
__Explores by smelling
__Discriminates odor
__Reacts negatively to smell
__Ignores unpleasant odors

Comments:_____
_____

SPEECH-LANGUAGE HISTORY:

SPOKEN LANGUAGE (Expressive Language). Check all that apply:
__Makes no sounds or makes sounds on a limited basis
__Uses gestures more than words to communicate
__Babbles only
__No true words
__Uses sign language. If yes, what signs:_____
__Produces only single words or short phrases
__Produces simple sentences
__Produces long sentences
__Produces long sentences which are disorganized or hard to understand what the child means
__Repeats words often or hesitates frequently
__Words are difficult to understand (articulation)
__Voice quality is unusual (e.g., hoarse, nasal, abnormally high pitched)
__Has difficulty recalling recent events
__Has trouble remembering the correct names of items or people
__Has no apparent problems expressing himself/herself
__Seems frustrated when attempting to relate events
__Stutters frequently

Approximately how many words does your child produce spontaneously:_____
Comments on any of the above:_____
_____
_____

COMPREHENSION (Receptive Language). Check all that apply:
__Does not understand spoken language
__Understands a few words
__Understands most words
__Understands simple conversations
__Understands everything said to him/her
__Follows simple commands
__Requires directions to be broken down in steps in order to follow
__Follows all directions easily
Comment on any of the above:_____
_____
_____

PRAGMATIC LANGUAGE (Social Skills). Check all that apply:
__Difficulty interacting with peers and/or adults
__Difficulty greeting/saying goodbye to others

__Difficulty with turn-taking
__Difficulty with maintaining conversations
__Makes frequent inappropriate remarks
__Difficulty making/maintaining eye contact
Comment on any of the above:_____
_____
_____

ARTICULATION (Check all that apply):
__Speech sounds are not understood by others
__Speech sounds are understood by others some of the time
__Speech sounds are understood by others most of the time
__Speech sounds are understood by others all of the time
Comment on any of the above:_____
_____
_____

If applicable, how severe do you think your child's language and/or articulation is:
__Severe __Moderate __Mild

Is your child aware of the problem: __Yes __No
How does he/she react:_____

Is any language other than English used in the home: __Yes __No
If yes, what language(s):_____
What percent of the time:_____

SCHOOL INFORMATION:
School:_____ Grade:_____
School Days: __Part day (AM/PM) __All day
Teacher:_____
Grades Repeated:_____ Grades Skipped:_____
Has your child been in a special classroom and/or attended any remedial classes: __Yes __No
If yes, describe what type, when, and when:_____
_____

Does your child have an IEP/IFSP: __Yes __No
If yes, please provide a copy to your therapist

Have you or the teacher observed that you child is (Check all that apply):
__Noticeably distracted in class
__Functions better in a one-to-one relationship rather than in classroom situations
__Has to be reminded how to hold pencil/paper when writing
__Needs to prop his/her head in hand while reading or writing at the desk

__Confused in right-left discrimination tasks (describe):_____
_____

__A poor speller

Which academic skills are the hardest:_____

If there are other concerns not covered in this form, please share:_____
_____
_____

Person completing this form:_____
Date:_____

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Consent for Release of Information

Date:_____

Patient Name:_____

Date of Birth:_____

I, _____, authorize the mutual exchange of information and/or medical records between Sensory Solutions and _____.

Signed:_____

Relationship to child:_____

*****By signing this release of information, I affirm that I am the parent or legal guardian of the name child and have been informed of the reason and need for this exchange of information. I understand that all information exchanged by these persons and/or agencies is confidential and will not be disclosed to any other party without the prior consent of the parent or legal guardian except as permitted by law. Information exchanged by these persons or agencies may be used for the purpose for which it was released. This information can be revoked at any time by submitting a written notice.**

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Patient History Form

***Please fill out the questionnaire as accurately and completely as possible.**

Child's Name:_____ Birthdate:_____
Diagnosis(es):_____
Referred by:_____
What are your concerns regarding your child?_____
_____
_____

Mother's Name:_____
Address:_____
Zip Code:_____ Cell Phone:_____ Home Phone:_____
Email:_____
Education:_____ Occupation:_____
Employer:_____ Work Phone:_____

Father's Name:_____
Address_____
Zip Code:_____ Cell Phone:_____ Home Phone:_____
Email:_____
Education:_____ Occupation:_____
Employer:_____ Work Phone:_____

Siblings (and ages):_____

Marital Status (Please check): __ Married __ Separated __ Divorced __ Widowed __ Single

Medical Insurance Company:_____
Whom will be responsible for payments:_____

Emergency contact information:
Name:_____ Relationship:_____
Phone Number:_____

Child's Pediatrician:_____
Address:_____
Zip Code:_____ Phone:_____ Fax:_____
How long has your child been under this physician's care?:_____

Sensory Solutions, LLC
Physical, Speech and Occupational Therapy for Children

MEDICAL HISTORY:

Pregnancy: ___ Full Term ___Premature
Length of Pregnancy:_____
Mother's general health during pregnancy: ____ Good ____Fair ____Poor
Problems encountered during pregnancy (e.g., illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.):_____
_____
_____

Length of total labor:_____ Difficult labor: __ Yes __No
Delivery Type:
__Vaginal
__C-section

Complications:
__Induced Birth
__Breech Presentation
__Limpness
__Stiffness
__Other:_____
Elaborate on above delivery complications:_____
_____
_____
_____

Length of hospitalization:_____ Child's birth weight: _____lbs. _____oz.

Complications:
__Jaundice
__Cyanosis
__Congenital defects
__Other:_____
__None

Was there a need for:
__Oxygen
__Transfusions
__Tube Feedings
__None
If so, please explain:_____
_____

Were there any feeding difficulties at birth: __Yes __No
Explain:_____
_____

Problems encountered during your child's first month:_____
_____

List illnesses/diseases your child has experienced:
Illness:_____ Age:_____
Illness:_____ Age:_____
Illness:_____ Age:_____

List injuries/operations your child has had:
Injury/operation:_____ Age:_____
Injury/operation:_____ Age:_____
Injury/operation:_____ Age:_____

Has your child experienced high fevers: __Yes __No
Age:_____ Temp:_____ Frequency:_____

Has your child experienced convulsions/seizures: __Yes __No
Age:_____ Type:_____ Frequency:_____ Medication:_____

Has your child experienced ear infections: __Yes __No Frequency:_____
Has your child had tubes placed: __Yes __No When:_____

Date of last hearing evaluation:_____ Results:_____
Where was the hearing evaluation completed:_____

Date of last vision evaluation:_____ Results:_____
Where was the vision evaluation completed:_____

Allergies:
__None
__Seasonal
__Food
__Other
Please list all allergies:_____
_____

History of acid reflux: ____Yes ____No
If yes, when and how was it treated:_____

Child's general health at present:
__Good
__Fair
__Poor

Is your child currently taking any medications: __Yes __No
If yes, type(s):_____
_____

SPECIALTY CONTACTS:

Specialty	Name of Agency/Specialist	Address	Phone
Audiologist			
Behavior Therapist			
Cardiologist			
Chiropractor			
ENT			
Occupational Therapist			
Ophthalmologist/ Optometrist			
Orthopedist			
Physical Therapist			
Psychologist/ Psychiatrist			
Speech Pathologist			
GI			
Other			

Sensory Solutions, LLC
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DEVELOPMENTAL HISTORY:

Check which of the following describes/described your child as an infant:
__Fussy
__Irritable
__Good
__Quiet
__Passive
__Active
__Liked being held
__Resisted being held
__Floppy when held
__Tense muscles when held
__Good sleep patterns
__Irregular sleep patterns

Check which of the following describes your child at present:
__Usually happy
__Mostly quiet
__Overly active
__Tires easily
__Talks constantly
__Too impulsive
__Restless
__Resistant to changes
__Clumsy
__Fights frequently
__Difficulty separating from primary caretakers
__Falls often
__Poor attention span
__Easily frustrated
__Cries often
__Cries infrequently
__Rocks self frequently
__Has difficulty learning new tasks
__Stubborn
__Overreacts
__Wets bed
__Frequent temper tantrums
__Nervous habits or tics

Approximate ages in which your child completed the following routinely:
Held up head (while on stomach):_____
Rolled over:_____
Belly crawled:_____
Crawled on hands and knees:_____
Sat independently:_____
Pulled to standing:_____
Standing independently:_____
Walking independently:_____
Babbling:_____ Were there a variety of sounds:_____
Producing single words:_____
Combining two words:_____

Does your child wear orthotics: __Yes __No Type:_____
Does your child require/use medical equipment:_____
Does your child use assistive devices for walking: __Yes __No Type:_____

General impressions of your child's motor development:
Gross Motor: __Slow __Normal __Advanced
Fine Motor: __Slow __Normal __Advanced
Handwriting: __Poor __Fair __Good

Does your child show a hand preference with:
__Feeding Which hand:_____
__Writing/Drawing Which hand:_____
__Throwing Which hand:_____
__Pointing Which hand:_____
__Cutting Which hand:_____

Has your child achieved skills and then lost them: __Yes __No
Explain (what and when):_____
_____

Has your child received prior therapy? (Please check all that apply):
___ First Steps ___ School ___ Outpatient facility similar to Sensory Solutions

FEEDING:
Bottle fed: __Yes __No Type of formula:_____
Nursed: __Yes __No

Currently eats:
__Breast milk
__Formula
__Baby food
__Junior foods
__Mashed table foods
__Table foods

Feeds self: __All __Most __Some __Rare

If feeds self, uses: __Bottle __Fingers __Spoon __Fork

Drinks from:
__Bottle __Sippy cup __Soft straw __Hard straw __Open cup

List most preferred foods:_____
_____
_____

List avoided foods:_____
_____
_____

SELF-CARE:
Bathes self: __All __Most __Some __None
Undresses self: __All __Most __Some __None
Dresses self: __All __Most __Some __None

Is your child toilet trained: __Yes __No
If yes, at what age:_____
__Bladder (daytime) __Bladder (day and nighttime) __Bowel

SENSORY HISTORY:

VESTIBULAR (Movement and gravity information). Check all that apply:
__Rocks while sitting
__Likes being tossed in the air
__Fearful of heights
__Likes Merry-Go-Rounds
__Gets car sick
__Enjoys being rocked: __Now __As an infant
__No fear of movement or falling
__Jumps a lot
__Good balance
__Fearful of movement
__Spins and Whirls more than others
__Prefers quiet play as opposed to active
Comments:_____
_____

TACTILE (Touch information). Check all that apply:
__Avoids messy things (mud, finger paints, etc.)
__Irritated by cloth of certain textures
__Dislikes unexpected touch
__Bangs head on purpose (now or in past)
__Mouths non-food objects
__Isolates self from others
__Excessively ticklish
__Dislikes nail cutting
__Seeks a lot of touch
__Dislikes face or hands washed
__Objects to being touched
__Avoids using hands for extended periods
__Pinches, bites, hurts self
__Feels pain less than others
__Strong like/dislike toward food textures
__Dislikes hair washing
__Wants to handle everything
Comments:_____
_____

PROPRIOCEPTIVE (Muscle and joint information). Check all that apply:

__Holds hands in strange positions
__Holds body in strange positions
__Good coordination with small items
__Walks on toes (or did when younger)
__Went from sitting to standing with little to no crawling
__Crept on tummy rather than hands and knees
__Leaps from one position to the next, unable to move slowly from one place to another

Comments:_____
_____

AUDITORY: (Check all that apply)

__Responds negatively to unexpected or loud noise
__Has difficulty paying attention when there are other noises nearby
__Misses hearing some sounds
__Seems confused as to the direction of sounds
__Seems to enjoy strange noises and/or makes loud noises
__Appears to be hard of hearing
__Enjoys music
__Has a diagnosed hearing loss
__Wears a hearing aid

Comments:_____
_____

VISUAL: (Check all that apply)

__Reversals in copying
__Happier in the dark
__Looks very closely at pictures/objects
__Difficulty discriminating shapes or colors
__Resists having eyes covered
__Squints often
__Becomes excited when there is a variety of visual objects
__Difficulty focusing on objects far away
__Difficulty focusing on close objects
__Wears glasses
__Difficulty maintaining eye contact
__Difficulty following objects across the room
__Sometimes shakes head awkwardly
__Difficulty following object tossed to him/her
__Shifts head to one side in order to look at an object

Comments:_____
_____

GUSTATORY-OLFACTORY (Taste and smell information). Check all that apply:

__Acts as though all food tastes the same
__Chews on non-food objects
__Has unusual cravings for certain foods
__Dislikes food of certain textures
__Explores by smelling
__Discriminates odor
__Reacts negatively to smell
__Ignores unpleasant odors

Comments:_____
_____

SPEECH-LANGUAGE HISTORY:

SPOKEN LANGUAGE (Expressive Language). Check all that apply:
__Makes no sounds or makes sounds on a limited basis
__Uses gestures more than words to communicate
__Babbles only
__No true words
__Uses sign language. If yes, what signs:_____
__Produces only single words or short phrases
__Produces simple sentences
__Produces long sentences
__Produces long sentences which are disorganized or hard to understand what the child means
__Repeats words often or hesitates frequently
__Words are difficult to understand (articulation)
__Voice quality is unusual (e.g., hoarse, nasal, abnormally high pitched)
__Has difficulty recalling recent events
__Has trouble remembering the correct names of items or people
__Has no apparent problems expressing himself/herself
__Seems frustrated when attempting to relate events
__Stutters frequently

Approximately how many words does your child produce spontaneously:_____
Comments on any of the above:_____
_____
_____

COMPREHENSION (Receptive Language). Check all that apply:
__Does not understand spoken language
__Understands a few words
__Understands most words
__Understands simple conversations
__Understands everything said to him/her
__Follows simple commands
__Requires directions to be broken down in steps in order to follow
__Follows all directions easily
Comment on any of the above:_____
_____
_____

PRAGMATIC LANGUAGE (Social Skills). Check all that apply:
__Difficulty interacting with peers and/or adults
__Difficulty greeting/saying goodbye to others
__Difficulty with turn-taking

__Difficulty with maintaining conversations
__Makes frequent inappropriate remarks
__Difficulty making/maintaining eye contact
Comment on any of the above:_____
_____
_____

ARTICULATION (Check all that apply):
__Speech sounds are not understood by others
__Speech sounds are understood by others some of the time
__Speech sounds are understood by others most of the time
__Speech sounds are understood by others all of the time
Comment on any of the above:_____
_____
_____

If applicable, how severe do you think your child's language and/or articulation is:
__Severe __Moderate __Mild

Is your child aware of the problem: __Yes __No
How does he/she react:_____

Is any language other than English used in the home: __Yes __No
If yes, what language(s):_____
What percent of the time:_____

SCHOOL INFORMATION:
School:_____ Grade:_____
School Days: __Part day (AM/PM) __All day
Teacher:_____
Grades Repeated:_____ Grades Skipped:_____
Has your child been in a special classroom and/or attended any remedial classes: __Yes __No
If yes, describe what type, when, and when:_____
_____

Does your child have an IEP/IFSP: __Yes __No
If yes, please provide a copy to your therapist

Have you or the teacher observed that you child is (Check all that apply):
__Noticeably distracted in class
__Functions better in a one-to-one relationship rather than in classroom situations
__Has to be reminded how to hold pencil/paper when writing
__Needs to prop his/her head in hand while reading or writing at the desk

__Confused in right-left discrimination tasks (describe):_____
_____

__A poor speller

Which academic skills are the hardest:_____

If there are other concerns not covered in this form, please share:_____
_____
_____

Person completing this form:_____
Date:_____

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