**Jane Gatanis, MA OTR/L, CST-C**
(917) 673-3176
JaneGatanis@gmail.com

# Pediatric History and Information  Age 2-12

Date: _______________

## General Information

Child's Name: ______________________________ Age:____ Date of Birth:____________

Parent 1 Name: ______________________ Parent 2 Name:________________________

Cell:_______________ Cell: _______________

Email: _____________________________ Email: ______________________________

Siblings (age): _________________________________________________________________

Pediatrician: ___________________________________

Referred By: ___________________________________

The following questions help create a more complete picture of your child from conception to present. Some questions may not apply. Please feel free to add any additional pertinent information.

## Prenatal History:

Difficulty Conceiving/Medical issues:

_____________________________________________________________________________

_____________________________________________________________________________

Stresses when pregnant (i.e. marriage, moving, trauma, illnesses, deaths):

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Family history of allergies/ADHD/digestion/sensory issues:

_____________________________________________________________________________

_____________________________________________________________________________

## Labor and Delivery

Length, Type and duration of delivery:

______________________________________________________________________

Complications/Interventions: ________________________________________________

______________________________________________________________________

Please write as much as you would like about delivery and child's first few minutes/days of life:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## Early History

Condition of Newborn: Apgar: ______ Weight/Height:__________

Feeding: (breast/bottle/combination/formula: ____________________________________

Feeding patterns (quality of latch and suck ie. on and off breast, unsettled, better one side vs other):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Digestive**

Colic Y / N

Reflux Y / N

Arching Pattern Y / N

Flatulence Y / N

Digestion/Elimination:

______________________________________________________________________

______________________________________________________________________

**Sleep:**

Crib/co-sleep: _____________________________________________________________

Sleep Patterns: ____________________________________________________________

Ability to self-soothe/restless sleeper: _____________________________________________

## Developmental History

Developmental Milestones (indicate age)

Sat Alone: ____________ Crawled: ____________ Walked: _____________ Ran: ______________

Used Words: __________ 2-word Sentence: _____________ 3-to-4-word Sentence: __________

Drank from Cup: ____________ Dressed Self: _______________ Used Spoon: ________________

Toilet training: ______________________________________________________________________

Ability to communicate: ______________________________________________________________

__________________________________________________________________________________

Social/Emotional development: _________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

**Present Status**

Recent or current illnesses: ________________________________________________

Surgery hospitalizations :_____________________________________________________

Recent or current medication: _______________________________________________

Allergies/sensitivities: _______________________________________________________

Eating: (picky/appetite) ____________________________________________________

Eye/visual issues: __________________________________________________________

Ear Infections/auditory difficulties: ____________________________________________

Activity level (low, medium, high)/interests/avoidance: ___________________________

Coordination: ______________________________________________________________

Language/communication: ____________________________________________________

**Self Care and Daily Routines:** Please describe how your child participates in each activity i.e. independence, need for assistance, avoidance, etc.

Dressing (include fasteners):_______________________________________________

Mealtime: ______________________________________________________________

Hygiene: _______________________________________________________________

Toileting (day/night, accidents, awareness):_________________________________

Transitions (changes between different people and environments):_______________

Organize and keep track of personal belongings:_____________________________

Sleep:__________________________________________________________________

**Therapies (past and present):**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Main Goals of Therapy**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________