Logo

Description automatically generated with medium confidence

**Child History Form**

Date : \_\_\_\_\_\_\_\_\_\_\_\_ Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) M( ) F DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) cell ( ) Home

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.com

□ Email or □ Text me appointment reminders: IF different # or email from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Appt Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings? Names/ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I hereby authorize and consent to the chiropractic evaluation and care of my child.*

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your main reason for today’s visit?**  ( ) Wellness Check - FYI: INSURANCE MAY DENY if no musculoskeletal issues ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List any other care your child has undergone with regard to this complaint including medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of onset (mm/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Onset was: ( ) Sudden ( ) Gradual ( ) Associated with an event

Duration of problem/episode: (Check one) Pattern of Problem: (Check one) \_\_\_\_ ( ) Minutes ( ) Hours ( ) Days ( ) Months ( ) Years  ( ) Constant ( ) Intermittent ( ) Occasional ( ) Cyclical

Initiating Factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aggravating Factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relieving Factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does the problem affect your child’s body function and daily activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior occurrence or episodes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF BIRTH**

( ) Hospital ( ) Birthing Center ( ) Home ( ) MD/DO ( ) Midwife

**Duration of Pregnancy**: \_\_\_\_ Weeks **Birth Weight** \_\_\_\_\_\_ **Birth Length** \_\_\_\_\_\_ **Hours in labor**: \_\_\_\_\_\_\_\_\_\_\_\_

Was the birth assisted? ( ) Yes ( ) No If yes, how? ( ) Forceps ( ) Vacuum extraction ( ) C-Section ( ) Induced Labor

Was the delivery considered ‘normal’? ( ) Yes ( ) Now If no, what were the complications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1\_\_\_\_\_\_\_

**Birth Position**: ( ) Head first ( ) Breech ( ) Other: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ APGAR at Birth \_\_\_/10 & after 5 minutes \_\_\_/10 □**UKNOWN**

**GROWTH AND DEVELOPMENT**

Was the infant alert & responsive within 12 hours of delivery? ( ) Yes ( ) No If no, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any apparent delays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any suspected delays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleeps on his/her-*choose all that apply*: ( ) Back ( ) Stomach ( ) Right side ( ) Left Side ( ) Both sides ( ) Incline ( )Unknown

Describe any major health problems that exist on the mother &/or fathers side of the family? (i.e. cancer, diabetes etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do the child’s siblings have any health problems? ( ) Yes ( ) No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***The following information is very important because many of the problems that chiropractors work with are caused by stressors.***

**CHEMICAL STRESSORS**

During pregnancy, did the mother: 1. Smoke ( ) Yes ( ) No 2. Drink alcohol? ( ) Yes ( ) No 3. Drink caffeine? ( ) Yes ( ) no

4. Take Rx/supplements? ( ) Yes ( ) No If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. Become ill? If so, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Did Mother exercise during pregnancy? ( )No ( ) Yes 8. Was/IS your child breastfed? ( ) No ( ) Yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. At what age was: Formula introduced? \_\_\_\_\_\_\_ Brand? \_\_\_\_\_\_\_\_ Cows milk?\_\_\_\_\_yrs/mos 10. Solid foods? \_\_\_\_\_ yrs/mos

11. Did your child receive vaccinations? ( ) Yes ( ) No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did your child react to them? ( ) Yes ( ) No

12. Has your child had antibiotics? ( ) Yes ( ) No If yes, how many & why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Any pets at home? ( ) Yes ( ) No 14. Any smokers at home? ( ) Yes ( ) No 15.Childhood illnesses? ( ) Yes ( ) No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PSYCHOLOGICAL STRESSORS**

Any difficulties with lactation? ( ) Yes ( ) No Any problems bonding? ( ) Yes ( ) No Avg # hours of TV/electronics per week \_\_\_\_\_hrs

Any behavioral concerns? ( ) Yes ( ) No if yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have difficulties sleeping ( ) Yes ( ) No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRAUMATIC STRESSORS**

Any evidence of trauma during birth? ( ) Bruises ( ) Odd shaped head ( ) Stuck in birth canal ( ) Fast &/or excessively long birth ( ) respiratory depression ( ) cord around neck ( ) other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any falls/accidents during pregnancy? ( ) Yes ( ) No Has the child had any major falls since birth ( ) Yes ( ) No If yes, did the child need stitches or obtain a fracture? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any hospitalization’s? ( ) Yes ( ) No Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child involved in any activities (Yoga; Tumbling, etc)? ( ) Yes ( ) No # Hrs/week? \_\_\_\_\_\_ Age child began \_\_\_\_\_

**Signature of Parent or guardian**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [2]

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and an art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

**Consent to evaluate and adjust a minor child:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Dr’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONSENT FORM**

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: Signature Date

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients. [4]

Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

|  |  |
| --- | --- |
| **Child’s First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:**  \_\_/\_\_/\_\_\_\_ **Gender (Circle one):**  Male / Female **Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

|  |  |
| --- | --- |
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|  |  |
|  |  |
|  |  |

**Do you have any medication allergies?**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Reaction | Onset Date | Additional Comments |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| ***For office use only***  Height: \_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure:\_\_\_\_\_\_ /\_\_\_\_\_\_  Temp:\_\_\_\_\_\_\_\_\_\_\_ Pulse:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

[6]

Logo

Description automatically generated with medium confidence **Developmental Milestones**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_  **M / F**

**GROSS MOTOR SKILLS FINE MOTOR SKILLS**

* 4 wks Able to hold head up from the table momentarily
* At birth Primitive grasp reflex present
* 4 mths Holds & shakes a rattle placed in hand
* 5 mths Grasps objects independently
* 6 mths Moves an object from 1 hand to other
* 6 mths Self-feeding, can hold & eat a cookie
* 6 mths Checks objects by placing them in Mouth
* 12 mths Picks up object w/ thumb & index Finger
* 15 mths Turns 2-3 pages of a book at a time
* 18 mths Turns pages of a book 1 at a time
* 24 mths Builds a tower containing at least 5 blocks
* 4 years Builds a tower containing at least 10 blocks
* 3 mths Head and shoulder can be supported by forearms
* 4 mths Infant can be pulled up into sit position by the

hands

* 6 mths Sits unsupported in the upright position
* 6 mths Head and shoulders can be supported by the arms
* 6 mths Rolls from a face down to a face up position
* 9 mths Crawls
* 9 mths Stands holding onto furniture
* 11 mths Walks with someone holding onto one hand
* 12 mths Walks unassisted
* 2 years Runs
* 2 years Negotiates stairs placing 2 feet on each step
* 3 years Climbs stairs using one foot on each step
* 4 years Walks downstairs with one foot on each step
* 4 years Hops on one foot
* 7 wks Makes cooing sounds
* 3 mths Laughs
* 5 mths Uses one syllable words, i.e. “da”
* 8 mths Uses 2 syllable words, i.e. “dada”
* 12 mths Uses 2 – 3 word vocabulary
* 24 mths Uses 2 – 3 word phrases

**COMMUNICATION SKILLS**

**ADAPTIVE SKILLS**

**SOCIAL SKILLS**

* 2 mths Smiles
* 3 mths Reaches for familiar objects
* 4 mths Plays with hands
* 6 mths Plays with feet
* 9 mths Clearly shows joy and pleasure
* 12 mths Feeds self with fingers
* 10 mths Feeds from a cup unassisted
* 12 mths Holds own bottle
* 30 mths Feeds self with utensils
* 30 mths Able to identify and match some colors
* 36 mths Copies a circle
* 42 mths Copies a cross
* 15 mths Plays peek-a-boo
* 18 mths Understands yes and no

**PARENT SIGNATURE:**

|  |  |
| --- | --- |
| * Fear Paralysis Reflex   + Low tolerance to stress   + Anxiety   + Sensory processing issues   + Hypersensitivity to light   + Hypersensitivity to sound   + Does not adapt to change well   + Overly clingy   + Extreme fatigue   + Selective mutism (not speaking in situations where talking is expected)   + Holding breath when upset or angry   + Obsessive-compulsive disorder (OCD) traits   + Defiant or controlling behavior * Plantar Reflex   + Did not crawl normally on hands and knees   + Poor balance   + Poor handwriting * Rooting and Suck Reflexes   + Difficulty chewing or swallowing   + Difficulties feeding   + Poor speech   + Poor articulation   + Lack of manual dexterity   + Poor appetite   + Picky eater   + Digestive issues   + Drooling   + Chews on items while concentrating   + Thumb sucking, nail biting   + Need for orthodontic treatment   + Separation anxiety * Tonic Labyrinthine Reflex (Forwards)   + Poor posture   + Car sickness   + Dislikes sporting activities   + Poor sense of time * Tonic Labyrinthine Reflex (Backwards)   + Poor balance and coordination   + Motion sickness   + Growing pains in legs   + Delayed walking   + Toe-walking   + Poor posture *i.e. head slumped forward* * Babinski Reflex   + Poor grounding and stability   + Difficulty with gross and fine motor coordination   + Passive in decision making   + Timid   + Toe walking * Palmar Grasp   + Poor handwriting   + Poor speech   + Poor articulation   + Poor fine muscle control   + Moves mouth or tongue when using hands *i.e. drawing*   + Poor manual dexterity   + Poor pencil grip   + Hypersensitive palms * Asymmetric Tonic Reflex (ATNR)   + Mixed laterality *i.e. right-handed and left-footed, ambidexterity*   + Poor eye-hand coordination   + Poor upper and lower limb coordination   + Difficulty reading and writing   + Poor distant vision   + Poor balance   + Difficulty with sports * Symmetric Tonic Reflex (STNR)   + Did not crawl on hands and knees *i.e. bear crawled, crab crawled, shuffled on bottom, etc.*   + Poor posture   + “W” sitting with legs on floor   + Poor hand-eye coordination *i.e. messy eater, clumsy child*   + Difficulty changing focus easily from whiteboard to desk   + Difficulty with copying words | * Moro Reflex   + Poor coordination   + Difficulty catching a ball   + Motion sickness   + Sensitivity to light   + Sensitivity to loud noises   + Difficulty reading black print on white paper   + Easily distracted   + Allergies   + Eczema   + Asthma   + Dislike of change   + Clingy   + Shy   + Hypersensitive to hair brushing, nail trimming, having face washing, wearing certain fabrics * Spinal Galant Reflex   + Bed wetting   + Constant fidgeting   + Unable to sit up straight   + Extremely ticklish   + Dislikes elastic waistbands or tags   + Poor concentration   + Poor short term memory   + Poor coordination with walking or running   + Not moving arms with walking   + Poor mobility with sports   + Low back pain   + Shallow breathing   + Digestive issues * Spinal Perez Reflex   + Poor head-leveling   + Low muscular tone *i.e. difficulty holding up head*   + Abnormal gait   + Tunnel vision   + Delayed crawling, frog-jump crawling   + Hyperactivity   + Sensory processing disorders   + Fears/phobias   + Bed wetting   + Discomfort with tightly-fitted clothes * Head-Righting Reflex (if underdeveloped)   + Poor balance and coordination   + Difficulty paying attention   + Experiences motion sickness   + Poor handwriting * Interhemispheric Integration   + Difficulty understanding direction   + Difficulty with reading   + Lack of crawling   + Weak suckle in infancy   + Immature dressing skills   + Difficulty with learning to swim, ride a bike   + Difficulty with organizational skills   + Impulsive   + Diminished concept of consequences * Underactive Right Hemisphere   + Poor spatial orientation   + Inappropriate social behavior   + Cannot reflect on own mental processes   + Poor nonverbal communication skills   + Poor attention   + Impulsivity   + Difficulty remembering what he/she just read   + Difficulty with math   + Eczema   + Allergies   + Asthma * Underactive Left Hemisphere   + Poor reading   + Delayed speech   + Poor auditory processing   + Poor object identification   + Poor verbal communication skills   + Depression   + Unable to write thoughts down   + Poor motivation |