2 Pillsbury Street, Suite 404
Concord, NH 03301
Phone: (603) 228-STAR (7827)
Fax: (603) 228- 7828
www.swingforthestars.com

Thank you for your interest in Swing for the Stars and Welcome! We look forward to meeting you and your child and working together to help your child achieve success. Attached you will find a Developmental and Medical History Form which we need you to complete and return *before* your evaluation. Once you have finished filling out the form, please return it via e-mail to Info@swingforthestars.com or mail it to our office.

One of our intake coordinators has given your scheduling availability to our scheduling team. As soon as we have a time available that fits your needs you will be contacted to schedule your child's evaluation followed by treatment.

If you should have any questions while filling out this form, please do not hesitate to contact us, and we will be happy to assist you. If your child has had any relevant evaluations within the last year that you would like the therapist to know about, please provide us with a copy of the evaluation

Again, thank you for your interest in receiving therapy at Swing for the Stars Pediatric Therapy Center and we look forward to working with you and your child in the near future.

Sincerely,

Swing for the Stars Team

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Developmental / Medical History Form

Please fill in all the information requested to the best of your knowledge. This information will be important for us during the evaluation process and will help us to better understand your child's needs. Your time and attention in completing this form is greatly appreciated. Thank you!

Identifying Information

Child's Name: _________________________ Date of Birth: _______________ Male ____ Female ____

Address: _____________________________ Diagnosis: ____

_____________________________ Presenting Concerns: __________________________________

Home Phone #: _________________________ ____

Primary Language at home: ______________ Primary Mode of Communication (signs, words, pictures: ____

_______________________________________ ____

Parent/Guardian(s) #1: ________________________________ Occupation: __________________________

E-Mail: ____ Employer: _____________________________

Preferred phone #: __________________________________ Type of phone: ________________________

Secondary phone #: _________________________________ Type of phone: ________________________

Parent/Guardian(s) #1: ________________________________ Occupation: __________________________

E-Mail: ____ Employer: _____________________________

Preferred phone #: __________________________________ Type of phone: ________________________

Secondary phone #: _________________________________ Type of phone: ________________________

Names and ages of the people currently living in your home:

Name	Age	Relationship to child

How did you hear about us?: ____

Primary Care Physician: __________________________________ Phone #: _____________________________

Address: ____ Fax #: _______________________________

____

Birth History

Describe your pregnancy (typical, non-remarkable, environmental stress, physical or emotional stress, complications): ____

____

Hospital delivered at: ___________________________________ Town/City: ____________________________

Was the baby full term: Yes_____ No_____ # Weeks: ______ Length of hospital stay: ________________

Vaginal or C-Section: ____________ Were suction or forceps used? Indicate which: _____________________

Weight at birth: _________________ Length: _________________ Apgar scores: 1 min______ 5 min______

Describe any complications during or after delivery: ____

____

Did your child require any additional medical attention (NICU, oxygen, etc)?: ___________________________

____

Did your child pass his/her newborn screening? If no describe why: ____________________________________

____

Infancy / Early Childhood

Please describe your child's early feeding history:

☐Breast Fed ☐Bottle Fed ☐Other (please describe): ____________________________________

____

Check the box that indicates your child's reaction to the following areas during infancy and early childhood

	Always	Frequently	Occasionally	Seldom/Never
Fussy / Colicky				
Good natured- non demanding				
Difficulties with eating				
Difficulties with sleeping				
Tolerate being left with caregiver				
Enjoyed being on stomach				
Enjoyed being held				
Enjoyed being on back				
Enjoyed bouncing				
Enjoyed swinging				
Tantrums / emotional outbursts				
Easily calmed or consoled when upset				

Please list the approximate ages at which your child met the following developmental milestones:

Milestone	Age Met	Milestone	Age Met
Roll over		Eat solid foods	
Sit unsupported		Drink from open cup	
Crawl		Use spoon independently	
Cruise		Feed self independently	
Walk		Put on shirt independently	
Speak first word		Put on pants independently	
Speak in sentences		Become toilet trained	

Medical History

Have you had any concerns regarding your child's overall development?: No______Yes_____ (explain below)

____

Please ✓ any health concerns that your child has or has had in the past

Concern	Past	Present	Concern	Past	Present
Allergies			Arthritis		
Asthma			Bedwetting		
Behavior problems			Birth or congenital malformation		
Cancer			Chicken pox		
Chronic diarrhea			Constipation		
Diabetes			Ear Infections		
Eczema			Emotional Problems		
Headaches (chronic)			High fevers		
Measles			Meningitis		
Poisoning			Seizures		
Urinary Tract Infections			Wetting during the day		
Sinusitis			Tonsillitis		
GERD					
Other:					

List any allergies or medical precautions your child has: ____

____

Is your child currently taking any medications on a regular basis? No______ Yes______ (complete below)

Medication Name	Dosage	Purpose of medication

Please list any evaluations your child has had prior to this assessment:

Date of Evaluation	Place of Evaluation	Name of Evaluator	Results of Assessment

When was the last time your child had his/her **vision** and **hearing** evaluated and what were the results? _______

____

Who completed the hearing and/or vision evaluation?: ____

____

Does your child have Pressure Equalizer/PE Tubes in their ears: ☐No ☐Yes When Placed: ____________

Please describe any past or present complications with PE Tubes: ______________________________________

____

Has your child had any surgeries or serious injuries? If so, please describe: ______________________________

____

Is there any more information that you feel we should know about your child: ____________________________

____

____

Education

Does your child currently attend school? No_____ Yes_____ (if so please fill out the remainder of this section)

Name of school: ______________________________________ Grade: _________

Classroom Type & Size: ____

Does your child receive any services at school? No _____ Yes_____

✓	Service Type	Frequency
	Occupational Therapy	
	Physical Therapy	
	Speech Therapy	
	Resource Assistance	

What parts of school does your child enjoy?: ____

____

What parts of school are most difficult for your child?: ____

____

Is your child involved in any extracurricular activities?: No______ Yes______

If so please list: ____

General Information

What are some of your child's favorite activities?: ____

____

What are some of your child's dislikes?: ____

____

What responsibilities does your child have at home?: ____

____

How would you describe your child (personality, strengths, etc)?: ______________________________________

____

____

General Information continued…

What areas of your child's development are you most concerned about at this point?: _____________________

____

What do you most hope to gain from this evaluation?: ____

____

What are your priorities for your child?: ____

____

Name of person completing this form: ________________________________ Date: ____________