



# NEURODEVELOPMENTAL THERAPY SERVICES, INC.

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## Client Information

Client Name: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Telephone:(h) \_\_\_\_\_ Alternate ph. \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ Cell Ph. \_\_\_\_\_

*Please complete and return to NTS prior to the client's initial evaluation. Thank you.*

### I. **Reasons for referral:**

In your own words, describe the client's need for services.

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Please describe any circumstances surrounding the onset of this problem.  
(illness, from birth...)

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### II. **Parent Concerns:**

What do you consider to be the two or three most important issues associated with the client's needs?

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What goals would you like to see the client achieve in treatment?

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Are you willing to participate in therapy sessions when the therapist feels it is appropriate?-AND- are you willing to use therapy strategies at home when appropriate?  
If no, why?

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Has the client previously received therapy? If yes, please list what type of therapy, where and how often they received services?

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Is the client currently receiving any other specialized instruction or services? If yes, where and how often? (i.e. cranial sacral, applied behavior approach, horseback riding)

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**III. Birth History:**

Please describe any difficulties associated with pregnancy or birth using the chart and lines below. Include any diagnoses made at birth.

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Premature		On time		Over due	
Vaginal		C-Section		NICU (how long)	
Labor induced		Labor lasted (hrs.)		Multiple birth	
Birth weight		Birth length		Apgar score	
Jaundice		Incubator		Intubated (how long)	
Feeding difficulty		Reflux		Breast or bottle-fed	

**IV. Medical History:**

Has the client had any serious illnesses or accidents? If yes, please describe and include any hospitalizations and surgeries.

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Is the client presently taking medications? Please list medication and reason for administration.

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Does the client have any allergies? If yes, please describe.

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Is the client on any special diet for nutritional or allergic reasons?

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Has the client ever had a seizure? If yes, please describe and list medications and techniques used to control seizures.

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Does the client have any vision problems? If yes, please describe the nature and management of the impairment.

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Has the client had any ear infections? If yes, how many?

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Does the client have tubes in his ears? If yes, for how long? When was the last time the tubes were checked?

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Does the client have any hearing loss? If yes, in one ear or both? What degree of loss is it and what frequencies does it cover? Does the client wear hearing aids or have other devices to help him hear?

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Has the client had any nose, throat or palate disorders (i.e.: clefts), procedures (i.e.: video fluoroscopy) or operations (i.e.: tonsils and adenoids removed)? Please describe below including dates.

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Has the client ever had a modified barium swallow study, an upper GI, a pH probe or a gastric motility study? If yes, please give the reasons why, and when the procedure was done, and any results of the procedure.

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**V. Developmental History:**

Estimate how many words the client speaks, or tell us if they are using complete sentences.

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If they are not using sentences, please give examples of the words they use.

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<b>Developmental Skills</b>	<b>Age</b>			<b>Remarks</b>
<i>1. At what age did the client first accomplish the following:</i>				
Sat alone				
Crawled				
Walked				
Babbled				
Spoke first word				
Combined 2-3 words				
Began eating pureed baby food				
Finger fed				
Self-fed (Utensil)				
Used a sippy cup				
Used an un-lidded cup				
Used a straw				
Bladder control				
Bowel control				
<b>Motor Skills</b>	<b>Yes</b>	<b>No</b>	<b>Sometimes</b>	<b>Remarks</b>
<i>2. Compared to others of the same age and sex, does the client seem to have difficulty:</i>				
a. manipulating small objects (i.e., buttons, knobs of toys)				
b. using pencils, crayons, scissors, paint-brushes				
c. catching a ball				
d. throwing a ball				
e. riding a tricycle (if under age 6)				
f. riding a bicycle (if over age 6)				
g. pumping self on the swing?				
h. kicking a ball				
<i>3. Compared with others, does your client more often seem to:</i>				
a. prefer sedentary activities (i.e., watching TV)				
b. prefer fine motor activities (i.e., coloring, building, with blocks)				
c. prefer gross motor activities (i.e., swinging, running)				
d. trip over or bump into things				
e. prefer indoor activities				
f. prefer outdoor activities				

Does the client have any oral motor difficulties including feeding, speech, or language?

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Does the client prefer certain foods or liquids including tastes, textures or temperatures?

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Does the client have difficulty with sucking, chewing, swallowing, using utensils, choking, reflux, tooth grinding or drooling? Include if they swallow foods whole or incompletely.

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What languages are spoken to the child? Home \_\_\_\_\_ School \_\_\_\_\_

Does the client have similar problems communicating in the other language(s)? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

Is the client using any sign language to communicate? (If yes, please list signs)

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Please describe any equipment the client is currently using for mobility, self-care, vision, hearing, communication, positioning or splinting.

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Does the client's home have any stairs? \_\_\_\_\_

Is there any information regarding the client's family history that is important to understand their current therapy needs?

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**VI. Social History:**

Client's current grade level: \_\_\_\_\_

Does the client experience any difficulty in preschool/school? Please describe.

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Please list any other family members or caregivers (parent, sibling, grandparent, nanny) who routinely look after the client. Include ages of any siblings.

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<b>Social Adjustment</b>	<b>Yes</b>	<b>No</b>	<b>Sometimes</b>	<b>Remarks</b>
1. <i>Compared with others of the same age, does the client:</i>				
a. find it hard to make friends among his peers				
b. prefer the company of adults to that of peers				
c. prefer to play with younger children rather than peers				
d. prefer to play alone				
e. frequently get discouraged easily, or express feelings of failure or frustration				
f. seem to have less fun when playing				
g. frequently express feelings of anger or frustration by hitting or kicking rather than with word				
h. frequently throw temper tantrums				
<b>School Performance</b>	<b>Yes</b>	<b>No</b>	<b>Sometimes</b>	<b>Remarks</b>
2. <i>Compared with others of the same age, does the client:</i>				
a. have poor handwriting				
b. make reversals of letters or numbers when writing or copying (if older than age 7)				
c. perform the same tasks with either hand (i.e., writing, eating)				
d. seem to tire quickly, have poor posture, or need to prop his or her head while reading or writing at a desk				
e. find gym class or sports to be a particular difficult or frustrating experience				
f. tend to clutter work areas excessively				
g. have excessive difficulty switching from active to quiet activities (i.e., playground to seatwork)				

Thank you for taking the time to fill out this questionnaire. This information will greatly assist the therapist working with the client in meeting his/her needs. Please feel free to make additional comments in the space below.