EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

662-380-5170
662-380-5271
info@ebscioxford.com
www.ebscioxford.com
104 Skyline Drive | Oxford, MS 38655

GENERAL INFORMATION

Child's Name: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Plan name: _____

Parent/Caregiver Name:	Phone Number	Email
1.		
2.		
3.		

Current concerns:

_____

_____

_____

Support Coordinator name: _____ Phone number: _____

FAMILY HISTORY

Child lives with:

- □ Birth parents
- □ Adoptive parents
- □ Foster parents
- □ Parent and step parent
- □ One parent
- □ Other:_____

If divorced, is it joint custody? Y N

If joint custody, can we communicate with both parents? Y N

Are we able to communicate with the step parent? Y N

Other explanation: _____

Other children in the family:

Name	Age	Gender	Speech/Hearing Difficulties/Diagnosis

Has any immediate or extended family member experienced the following?

- □ Hearing Problems
- □ Learning Problems
- □ Cognitive Delay
- □ Seizure Disorder
- □ Congenital Disorder
- □ Autism
- □ Stuttering

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What is the primary language spoken in the home? _____

Please list any additional languages spoken in the home: _____

PREGNANCY- Please indicate "Y" for yes and "N" for no

Y	N	Bleeding	Y	N	Maternal drug/alcohol use
Y	N	Excessive weight gain	Y	N	Pre-term labor
Y	N	Limited weight gain	Y	N	Gestational diabetes
Y	N	Toxemia	Y	N	Infections
Y	N	Seizure disorder	Y	N	Multiple birth
Y	N	Maternal medications (Please list):			

_____

DELIVERY- Please indicate "Y" for yes and "N" for no

Y	N	Difficult birth	Y	N	Baby had respiratory distress
Y	N	Prolonged labor	Y	N	Oxygen needed for child
Y	N	Breech birth	Y	N	Cord around baby's neck
Y	N	Brief Labor	Y	N	Cesarean sections
Y	N	Baby treated for jaundice	Y	N	Umbilical cord knot

Other complications: _____

Were any of the following used during delivery: Epidural Forceps Vacuum suction

Length of pregnancy: _____

Days in the hospital before discharge: _____ Baby's weight: _____

NEWBORN/NURSERY- Please indicate "Y" for yes and "N" for no

Y	N	NICU stay	Y	N	Hearing screening Pass Referral
Y	N	Sucking difficulties	Y	N	Brain bleed (if yes, indicate grade level)
Y	N	Breathing machine			I II III IV
			Y	N	Was it resolved?

If "yes" for NICU, how long was the stay: _____

What was the reason for the stay: _____

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MEDICAL HISTORY- Please indicate "Y" for yes and "N" for no

Y	N	Adenoidectomy	Y	N	Lung Problems
Y	N	Asthma/RAD	Y	N	Measles
Y	N	Chronic ear infections	Y	N	Meningitis
Y	N	Cleft Lip/Palate	Y	N	Mumps
Y	N	Depression	Y	N	Pneumonia
Y	N	Ear tubes	Y	N	Scarlet fever
Y	N	Encephalitis	Y	N	Seizures
Y	N	Failure to Thrive	Y	N	Surgeries
Y	N	Head injury	Y	N	Thumb/finger sucking
Y	N	Heart Problems	Y	N	Tonsillitis/Tonsillectomy
Y	N	Anxiety	Y	N	High fevers
Y	N	Allergies(Please list): _____			
Y	N	Other: _____			

Other hospitalizations: _____

Current medications (name, dosage and frequency): _____

_____

Primary Care Physician name_____ Phone Number_____

Office Address

_____

Adaptive equipment/assisted technology: _____

Y	N	Do you have any concerns with your child's vision?
		Last vision screening date:
Y	N	Does your child wear glasses?
Y	N	Do you have any concerns with your child's hearing:
		Last hearing screening date:
Y	N	Do you have any concerns regarding your child's oral health?
		Last dental examination:
Y	N	Are immunizations up to date? If not, please explain: _____
		_____
Y	N	Does your child have a diagnosis? *If so, please list:* _____

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Y	N	Allergist	Y	N	Occupational Therapist
Y	N	Cardiologist	Y	N	Pulmonologist
Y	N	Dietician	Y	N	Physical Therapist
Y	N	Gastroenterologist	Y	N	Speech-Language Pathologist
Y	N	Neurologist	Y	N	Other: _____

DEVELOPMENTAL HISTORY

At what age did your child do the following? Indicate "N," if they have not accomplished it.

Communication	Gross Motor	Fine Motor
• Cooed/babbled ____ • First word ____ • Followed 1-step direction ____ • Used two words together ____	• Head control _____ • Roll both ways _____ • Sat alone _____ • Crawl _____ • Walk _____ • Jump _____ • Hop on 1 foot _____ • Rode bike _____	• Point with index finger _____ • Finger feed _____ • Ate with spoon _____ • Cut with scissors _____ • Drew a circle _____ • Removed clothing _____ • Put on clothing _____ • Put on shirt independently _____ • Buttoned independently _____ • Zipped independently _____ • Toilet trained _____ • Combed hair _____ • Bathed independently _____ • Tied shoes _____

EDUCATIONAL HISTORY

Did or does your child attend pre-school? _____

What grade is your child in: _____

What is the name of your child's school? _____

What district is the school in: _____

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Is your child in: General education Resource Self-contained

What is your child's teacher's name: _____

Is it okay to contact the teacher? Y N

Is your child receiving any services in the school? Speech OT PT
Adaptive P.E. Social Work

Any concerns with academic skills? Y N

Any concerns with social skills? Y N

Hand preference? Left Right Difficulty with handwriting? Y N

BEHAVIORAL HISTORY

Behavior Characteristics:

Y	N	Aggressive	Y	N	Plays with others
Y	N	Short Attention	Y	N	Poor eye contact
Y	N	Uncooperative	Y	N	Prefers to play alone
Y	N	Transitioning to (activities, places)	Y	N	Engages is repetitive behaviors
Y	N	Cries, screams often	Y	N	Self-Injurious behavior
Y	N	High activity level	Y	N	Walks on tip toes
Y	N	Impulsive regularly	Y	N	Seeks/avoids movement (circle)
Y	N	Willing to try new things	Y	N	Withdrawn
Y	N	Distracted/avoidant of loud noises	Y	N	Property Destruction
Y	N	Avoids certain textures/temperatures-(Please list):			

_____

_____

CURRENT COMMUNICATION

Does your child…

□ Repeat sounds word or phrases over and over?

□ Understand what you are saying?

□ Retrieve/ point to common objects upon request?

□ Follow simple directions?

□ Respond correctly to yes/no questions?

□ Respond correctly to wh-questions?

What does your child currently use to communicate?

□ Joint Attention

□ Sounds (vowels, grunting)

□ Words

□ 2-4 word phrases

□ Sentences

□ Augmentative Communication Device

□ Other?_____

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FEEDING DEVELOPMENT

y N Do you have concerns regarding your child's feeding skills? If yes, please explain

_____

_____

Y N Food allergies? If yes, please list:

_____

_____

Please describe the types of food your child eats. (Include type, texture, baby food, table food, etc.)

_____

Where does your child usually eat? (ex: highchair, table, lap):

Y N Any history of difficulty taking the breast/bottle? If yes, please explain:

_____

Y N Any history of reflux or issues associated with feeding? If yes, please explain:

_____

FAMILY CONCERNS AND EXPECTATIONS

What are some of your child's strengths and interests? _____

_____

What are your concerns about your child? _____

_____

What do you hope to gain for your child and yourself/family from this program? _____

_____

Y N Are you interested in information regarding social services? (ex: psychology/family counseling, grief counseling):

_____

Y N Has your child ever been enrolled in another private therapy program? If yes, please explain:

_____

Agency/Program: _____

City/State: _____

Date Range of Therapy: _____

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Services received: _____

THERAPY	# MIN. PER WEEK	CURRENT OR PAST DATE RANGE	APPROXIMATE DATE OF LAST EVALUATION
Speech/Language Therapy			
ABA/Behavior Therapy			
Physical Therapy			
Occupational Therapy			
Psychology/Counseling/SW			
Social Skills Group			

Y N Do you give consent for an evaluation and/or therapies to be provided by EBS Children's Institute of Oxford?

Y N Do you consent to obtain any evaluations/documentation in person per our standard method of delivery? If not, your evaluation will be mailed to you at the address provided.

Y N Special training is required for the provider

Behavior Treatment Plan Available? Y N Reason for BTP? _____

Method used to gather information: _____

_____ _____
Print/ Signature of Parent or Guardian Date

_____ _____
Print/ Signature of Parent or Guardian Date

_____ _____
Print/ Signature of Provider Date

_____ _____
Print/ Signature of Provider Date

Thank you for choosing EBS Children's Institute of Oxford to serve your child and family!