Dream Riders at Midwest Center for Children's Development
Pre-Evaluation Packet

Please fill out and return to Dream Riders to continue the intake process.

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Patient Demographics

Name of patient: _____ D.O.B. _____ M ☐ F ☐

Name of Parent or Guardian_____ Patient's Height and Weight_____

Primary Diagnosis_____

- How did you hear about our program?
- Do you have a specific doctor you would like evaluations, progress notes, etc. to be sent to? If so, please include his/her name:

Parent/Family Concerns

1. What are the primary concerns with your child's development? What are your goals for therapy?

2. What areas of development are causing concern? Please check yes/no

Developmental Area	Yes	No
Ability to calm themselves		
Activities of Daily Living		
Attention		
Behavior		
Eating/Feeding		
Hand use		
Hearing		
Mobility		
Motivation		
Motor Control/Planning		

Developmental Area	Yes	No
Play		
Positioning		
Sensory integration/regulation		
Sleeping		
Social Interaction		
Speech/Language		
Temper tantrums		
Transfers		
Vision		
Weight/Growth		

Pregnancy/Delivery

3. Pregnancy proceeded (circle one): Normal / Complications
4. Length of pregnancy (number of weeks):
5. Delivery proceeded (circle one): Normal / Complications
6. Delivery was (circle one): Vaginal, C-section, emergency C-section
7. Child's length of hospital stay after birth (days/weeks/months):
8. Were there any of the following pregnancy complications? Please check yes/no

Pregnancy complication	Yes	No
Eclampsia		
Gestational diabetes		
Multiple births		
Polyhydramios		
Positive CMV		

Pregnancy complication	Yes	No
Positive Strep-B		
Pre-eclampsia		
Premature labor		
Substance exposure		
Toxemia		

Positive Herpes			Other: Please specify		
Positive HIV					

9. Were there any of the following delivery complications? Please check yes/no

Delivery complication	Yes	No	Delivery complication	Yes	No
Abruption placenta			Premature rupture of membranes		
Breech presentation			Prolapsed cord		
Low birth weight			Use of forceps		
Negative vacuum			Substance exposure		
Non-progressive/unproductive labor			Umbilical cord around neck		
Occiput posterior position			Uterine rupture		
Placenta previa			Other: Please Specify		

Birth information

10. Mothers age at time of birth:
11. Birth hospital:
12. Needed to be transferred to another hospital (yes/no; if so what hospital):
13. Birth weight/height:
14. Please add any other comments regarding pregnancy or birth:

Following birth

15. Did any of the following complications occur following birth? Please check yes/no

Postnatal complication	Yes	No	Postnatal complication	Yes	No
Anemia of prematurity			Necrotizing entercolitis (NEC)		
Brohopulmonary dysplasia (BPD)			Neonatal hypoxia		
Cleft lip			Oxygen deprivation		
Cleft palate			PDA		
Club foot			Positive dependency		
Cytomegalovirus			Respiratory distress syndrome		
ECMO			Respiratory stridor		
Failure to thrive			Respiratory syncytial virus (RSV)		
Hyperbiliruinemia			Retinopathy of prematurity (ROP)		
Intrauterine growth retardation (IUGR)			Thrombocytopenia (Low platelet count)		
IVH Bleed (if so, what grade?)			Ventilator dependency		
Jaundice			VP Shunt		
Meconium aspiration			Other complications		

16. Has your child been diagnosed with any specific diagnosis or syndrome(s)? Or are there any suspected diagnosis or syndrome(s)?

Medications/Allergies

17. What medication(s) is your child currently taking?

18. What vitamins, herbs, minerals, etc. is your child currently taking?

19. Does your child have any known allergies?

20. What was the date of the latest hearing test? What were the results?

21. What was the date of the latest vision test? What were the results?

Tests/Procedures

22. List all physicians, their specialty, and date of last visit your child sees:

Physicians	Specialty	Reason of Visit	Date of Last Visit

23. List all surgeries/procedures and date your child has received:

Physicians	Surgery:	Date of Surgery

24. List all diagnostic tests, dates, and results your child has received: (i.e., EEGs, swallow study, etc.)

Test	Date performed	Details/Results

Medical concerns

30. Has your child/does your child have any of the following medical concerns? Please check yes/no

Medical concern	Yes	No
Allergies		
Arteriovenous malformation (AVM)		
Anoxic brain injury		

Medical concern	Yes	No
Muscular dystrophy		
Osteoporosis		
Periventricular leukomalasia		

Asthma/respiratory problems		
Autism		
Baclofen pump		
Cerebral palsy		
Cerebral vascular accident (CVA)		
Chronic ear infections		
Colic		
Constipation		
Diarrhea		
Down syndrome		
Hydrocele		
Hip subluxation (degrees?)		
Laryngomalacia		

Reflux		
Scoliosis (degrees?)		
Seizure condition		
Sleep disorder/problems		
Shunt		
Torticollis		
Traumatic brain injury (TBI)		
Tube feeding		
Tubes in ears		
Vagal nerve stimulator		
Orthopedic conditions: (Specify)		
Neurological conditions: (Specify)		
Other:		

If child has a seizure condition, what do they look like? What is their specific seizure protocol?

Motor/Play Development

31. When did the child begin to (what age? Or specify if they are not yet doing this task):
    a. Rolling over?
    b. Sitting alone without support?
    c. Began to crawl?
    d. Standing unsupported?
    e. Walking unaided?
    f. Fully toilet trained?
    g. Self-bathing?
    h. Self-dressing?
32. Is your child left or right handed?
33. Are there concerns with handwriting?
34. How does your child primarily get around the home?
35. What are the child's favorite toys and play activities?

Sensory Processing/Regulation

36. Does your child have any of the following behaviors/characteristics? Check yes/no

Behavior/Characteristic	Yes	No
Avoids getting messy		
Seeks out (craves) touch or movement		
Stumbles or falls frequently		
Appears awkward or less coordinated		
Flaps hands		
Bangs on surface, bands/hits head		
Fatigues quickly		

Behavior/Characteristic	Yes	No
Walks on toes		
Lines up toys or objects		
Seeks out visually stimulating objects		
Seeks out stimulating sounds		
Resists certain movements		
Has difficulty figuring out how to move body or takes more time with movements		
Does not tolerate certain textures		

Has self-abusive behaviors		
Resists certain tasks or environments		
Spins things or self		
Is sensitive to lights, sounds or noise		
Resists touch		

Uses a lot of pressure when touching someone or holding object		
Has difficulty with transitions		
Has poor sense of body in space, runs into things		
Seeks support for posture		
Hyperfocused		

Social/Emotional Skills

Behavior/Characteristic	**Yes**	**No**
Is easily distracted		
Calms self easily		
Gets angry/frustrated easily		
Is aggressive towards others		
Has poor eye contact		

Behavior/Characteristic	**Yes**	**No**
Prone to emotional outbursts		
Doesn't allow others to join in play		
Prefers to play alone		
Has difficulties with separation from parent		
Difficulty following directions		

Speech and Feeding:

37. What is your child's primary way of communication (circle one)? Verbal / Non-verbal
38. Does your child use an augmented communication device (circle one)? Yes / No
39. Describe any feeding current or past concerns:

40. Food preferences:
41. Food dislikes:
42. What are feeding areas of difficulty? Please check yes/no

Area of Difficulty	**Yes**	**No**
Chewing		
Communicating needs		
Transitioning between foods		
Jaw shifts/slides/juts		
Drooling		
Swallowing		
Understanding words		

43. Are there any current feeding adaptations (Thickened liquids, adapted utensils, adapted seating, calories supplements, tube feeding, etc.)? If so, please describe specifics.

44. Communication skills; please specify yes/no to the following questions:

Does the child have:	**Yes**	**No**
Speech that is understood by most people?		
Respond correctly to yes/no questions?		
Follow simple instructions?		
Respond when name is called?		
Stutter?		
Recognize objects, people, and places?		

45. When did the child begin (at what age)?

    a. Babbling?
    b. Saying first words?
    c. Naming familiar objects?
    d. Putting 2 words together?
    e. Using short sentences?

46. What was his/her first word(s)?

47. If the child is verbal, select the primary methods of communication:

Type of verbal communication	**Yes**	**No**
None		
Vocalizations		
Single word phrases		
2 word phrases		
Complete sentences		

48. If the child is non-verbal, select the primary methods of communication:

Type of non-verbal communication	**Yes**	**No**
Facial expressions		
Body language		
Manual sign language		
Gestures		
Pointing		
Eye gaze		

49. Are there any other communication concerns at this time?

Home

50. Who does the child live with (e.g. mother, father, step-parents, siblings, grandparents, etc.)?

    a. Please list age of siblings if applicable

51. How many stairs to get into the home?

52. Please fill out and check all that apply

Equipment	**Age of equipment**	**Details**	**Used at home?**	**Used at school?**
Braces				
Walker				
Stander				
Manual wheelchair				
Power wheelchair				
Weighted vest				
Hand splits				
Other				

53. Do you currently perform a home program with the child (stretching, strengthening activities, brushing etc.)?

    If so, please describe.

54. Is the child involved in any community groups or sports activities? If so, please describe.

Therapy/School History

55. What grade in school is your child?

56. Where do they go to school?

57. Does your child have an IFSP (0-3) or IEP (school)?

58. Has your child had a psychological or neuropsychological evaluation completed?

59. Please fill out the following regarding therapy services your child is receiving.
Service refers to the discipline received.
Status refers to ongoing or discharged (received in the past).
Frequency refers to how often these services were received (1x/week, 2x/month, etc.). Location refers to where services were received (home, school, outpatient, etc.).

Service	**Status**	**Frequency**	**Location**
Audiology			
Behavior therapy			
EI services			
Vision therapy			
Nutrition			
Occupational therapy			
Physical therapy			
Social work			
Speech/language therapy			
Developmental follow-up clinic			
Other			