Initial Profile

Date seen:

1. **Personal Details:**

Child's name: Date of birth:

Parents' Name(s) Carers' Name(s)

Number of children and ages in Family:

Home address:

Telephone numbers

Emergency contact number{s}

Method of referral:

Diagnosis given:

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First indication of problem{s}:

2. **History of pregnancy: (include important details)**

- Length of pregnancy: premature normal post-mature

3. **Details of birth and after:**

- Place of birth:
- Length of labour:
- Birth: normal Weight:
  Caesarean
  Vacuum
  Forceps
- Breathing problems:

  Oxygen? If so, how long for:

- Apgar scores:
- Special Care:
  - How long :
- Tube feeding:
- Seizures:

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- Medication:

- Tests: CAT MRI

  Any professional remarks regarding the scans?

4. **Additional birth information:**

5. **Discharge details:** Age/state of health/remarks from Doctors

6. **General health:**

- Vaccinations/ Immunizations:

- Early childhood illnesses:

7. **Child's present condition:**

- Height:
- Weight:

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- Head development:
- circumference:
- Microcephaly
- Macrocephaly
- Hydrocephalus

  Is Shunt used?

- Contractures/ dislocations:

- Hip x-ray:

- Operations:

8. **Motor development:**

- Muscle tone:

- Supine:

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- Prone:
- Sitting up/ sitting:
- Standing up/ standing:
- Changing places/ mobility:

9. **Fine motor development { manipulation}:**

- Grasp/ release/maintaining grasp:
- Flat hands:
- Isolate thumb/ index finger:
- Pincer grasp:
- Does the child demonstrate preference for one hand?
- Does the child transfer toys etc. from one hand to the other?
- Can child put hands together in midline { e.g. clap; clasp} :
- Hands crossing midline:

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10. **Vision:**

- Date of last test:
- Where:
- Outcome:

11. **Hearing:**

- Date of last test:
- Where:
- Outcome:

12. **Eating/ Drinking:**

- Biting/Chewing:
- Swallowing:
- Any problems with eating e.g. tongue thrust, bite reflex, lip closure, using tongue to move food around etc. :
- Finger feeding:
- Spoon etc. How? What type of spoon?
- Drinking – bottle; cup with lid, beaker, open cup etc. (any and all methods used by child)

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- Any problems with drinking?
- Drooling:
- SLP's/Feeding Therapist's Report?

13. **Communication:**

- Sounds:
- Babbling:
- Words- How many? Clarity?
- Non-Verbal:
- Augmentative System:

14. **Learning abilities:**

- Awareness of self, others, environment, activities?
- Interest in toys, books, activities etc.
- What are the favorite Toys?
- Dislikes?
- Attention/ Concentration:
- Response to verbal/visual stimulus:

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15. **Behaviour:**

- Happy, unhappy
- Irritable
- Crying a lot
- Apathy/ Passive
- Restless/ Restful
- Demanding
- Manipulative
- Other

16. **Sleeping:**

- Any problems:
- Alone:
- Routine:
- Sleep during the day:
- Recognition of meaning of bedtime:

17. **Dressing/ Undressing:**

- Participation- arms through holes, pulling off socks etc.
- Any other dressing/undressing observations?

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18. **Pottying / Toileting:**

19. Current Treatments:

Physiotherapy:

- Name:
- Address:
- Frequency:
- Place of treatment:
- Duration of session:

Speech and Language Therapy:

- Name:
- Address:
- Frequency:
- Place of treatment

Occupational Therapy;

- Name:
- Address:
- Frequency:
- Place of treatment:

- Any other e.g. cranial osteopathy, aromatherapy, reflexology, homeopathy, chiropractic, hippo therapy, Anat Baniel etc.

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20. Special Aids:

- Piedro boots, AFOs, gaiters, arm splint, brace etc.

- Special chair:

- Standing frame:

- Walker, sticks etc.

- Other (bike, tricycle, etc.):

21. Education:

- Playgroup/EI Group/Home Based EI etc.:

- Preschool/Kindergarten:

- School:

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22. Conclusion:

- What do parents feel the difficulties are?

- Why did they choose the Conductive Education approach?

- Knowledge of Conductive Education?

- What are the parents / caretaker's expectations from Conductive Education?

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