**Initial Profile**

1. **Personal Details:**

Child’s name: Date of birth:

Date seen:

Parents’ Name(s) Carers’ Name(s)

Number of children in Family:

Home address/telephone number Emergency contact number{s}

Method of referral:

Diagnosis given:

First indication of problem{s}:

1. **History of pregnancy:**

* Length of pregnancy: premature normal post-mature

1. **Details of birth/after birth:**

* 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:
* Medication:
* Tests: CAT MRI

1. **Additional birth information:**

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

**6. General health:**

* Vaccinations/ Immunizations:
* Early childhood illnesses:

1. **Child’s present condition:**

* Height:
* Weight:
* Head development:
* circumference:
* Microcephaly
* Macrocephaly
* Hydrocephalus

Is Shunt used?

* Contractures/ dislocations:
* Hip x-ray:
* Operations:

1. **Motor development:**

* Muscle tone:
* Supine:
* Prone:
* Sitting up/ sitting:
* Standing up/ standing:
* Changing places/ mobility:

1. **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:

1. **Vision:**

* Date of last test:
* Where:
* Outcome:

1. **Hearing:**

* Date of last test:
* Where:
* Outcome:

1. **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)
* Any problems with drinking?
* Drooling:
* SLP’s/Feeding Therapist’s Report?

1. **Communication:**

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

1. **Learning abilities:**

* Awareness of self, others, environment, activities?
* Interest in toys, books, activities etc.
* What is your favorite?
* Dislikes?
* Attention/ Concentration:
* Response to verbal/visual stimulus:

1. **Behaviour:**

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

1. **Sleeping:**

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

1. **Dressing/ Undressing:**

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

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.

**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:

**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?

**23. Outcome:**