Children's Therapy Center

Occupational Therapy

Today's Date: _____ /_____ /_____

Child's Name: _____

Date of Birth: _____ /_____ /_____ Height: _____ ' _____ " Weight: _____ lbs

How did you hear about us? _____

Emergency Contact Name: _____

Emergency Contact Phone: (_____)_____-_____ Emergency Contact Relationship: _____

What is the main reason you are seeking help for your child? _____

_____

Please list the names and relationships with whom the child is living: _____

_____

Please list the names and relationships of any non-residential adults with whom the child is primarily involved:

_____

MEDICAL STATUS

Food or medical allergies: _____

_____

Illnesses currently being treated: _____

_____

Medications presently taken: _____

_____

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases (describe any complications): _____

_____

Hospitalizations: _____

_____

Surgeries: _____

Head injuries (indicate level of unconsciousness): _____

Occupational Therapy (continued)

MEDICAL HISTORY (continued)

Coma: _____ Convulsions: _____

Meningitis or encephalitis: _____

Immunization reactions: _____

Persistent high fevers (include highest temperature): _____

Eye problems: _____ Ear problems: _____

PREGNANCY

Mother's age at time of birth: _____

Complications:

Vomiting ☐ Yes ☐ No Threatened miscarriage ☐ Yes ☐ No

Excessive blood loss ☐ Yes ☐ No Toxemia ☐ Yes ☐ No

Infections: _____

Surgeries: _____

Other illnesses: _____

Smoking during pregnancy? ☐ Yes ☐ No Number of cigarettes per day: _____

Alcohol during pregnancy? ☐ Yes ☐ No Describe: _____

Medications or other drugs during pregnancy: _____

LABOR

Duration of labor: _____ Circle one: Spontaneous / Induced

Type of delivery: Vertex (normal) / Breech / Caesarean

Birth weight: _____ lbs _____ oz

Gestational age: (AGA) Approriate / Small (SGA)

Complications:

Cord around neck ☐ Yes ☐ No Hemorrhage ☐ Yes ☐ No

Injury during delivery: _____

Other (specify): _____

Respiration: Immediate / Delayed How long? _____

Cry: Immediate / Delayed How long? _____

Mucus accumulation ☐ Yes ☐ No Jaundice ☐ Yes ☐ No

Occupational Therapy (continued)

LABOR (continued)

Cyanosis (turned blue) ☐ Yes ☐ No

Incubator care ☐ Yes ☐ No How long? _____

Suck: Strong / Weak

Other complications: _____

INFANCY—TODDLER PERIOD

Were any of the following present to a significant degree during the first few years of life? If so, describe:

Did not enjoy cuddling _____

Not calmed by being held or stroked _____

Colic _____

Excessive restlessness (including diminished sleep) _____

Frequent head banging _____

Constantly into everything _____

Excessive number of accidents _____

DEVELOPMENTAL MILESTONES

Indicate the age at which your child reached the following developmental milestones. If you cannot recall, check off the approximate time:

	Age	Early	Normal	Late
Smiled				
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words				
Said phrases				
Said sentences				
Bladder trained				
Bowel trained				
Rode tricycle				
Rode bicycle				
Buttoned clothes				
Tied shoelaces				
Named colors				
Said alphabet in order				
Began to read				

Occupational Therapy (continued)

COORDINATION

Rate your child on the following skills:

	Strong	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic ability			

COMPREHENSION & UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children of the same age?

☐ Yes ☐ No Why or why not? _____

How would you rate your child's overall level of intelligence compared to others of the same age?

☐ Below average ☐ Average ☐ Above average

SCHOOL

Rate your child in regards to academic achievement:

	Strong	Average	Poor
Preschool			
Kindergarten			
Current Grade			

Has their classroom teacher made note of any of the following?

- Does not sit still in seat ☐ Yes ☐ No
- Frequently gets up and walks around the room ☐ Yes ☐ No
- Shouts out; does not wait to be called upon ☐ Yes ☐ No
- Will not wait for turn ☐ Yes ☐ No
- Does not cooperate in group activities ☐ Yes ☐ No
- Does not pay attention during storytelling ☐ Yes ☐ No
- Does not respect the rights of others ☐ Yes ☐ No

Describe any other classroom behavioral issues: _____

_____

Occupational Therapy (continued)

PEER RELATIONSHIPS

Does your child seek friendships with peers? ☐ Yes ☐ No

Is your child sought by peers for friendship? ☐ Yes ☐ No

Your child plays primarily with others who are… Same age Younger Older

Briefly describe any issues your child may have with peers: _____

_____

HOME BEHAVIOR

All children, to some degree, exhibit the kinds of behaviors listed below. Check off those that you believe your child exhibits to a higher degree when compared to peers of similar age:

- Hyperactivity (high activity level) _____
- Poor attention span _____
- Impulsivity (poor self-control) _____
- Easily frustrated _____
- Outbursts & screaming _____
- Sloppy table manners _____
- Interrupts frequently _____
- Does not listen when spoken to _____
- Hits other children _____
- Heedless to danger _____
- Excessive number of accidents _____
- Does not learn from mistakes _____
- Poor memory _____
- Poor relationships with siblings _____

INTERESTS & ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____

_____

What are a few of your child's greatest accomplishments? _____

_____

What does your child like doing the least? _____

_____

Occupational Therapy (continued)

MOTHER

Occupation: _____ Highest grade completed: _____

Medical issues (specify): _____

Learning delays (specify): _____

Illnesses or diseases that run on mother's side of family: _____

FATHER

Occupation: _____ Highest grade completed: _____

Medical issues (specify): _____

Learning delays (specify): _____

Illnesses or diseases that run on mother's side of family: _____

SIBLINGS

Name	Age	Medical, social or academic issues

LIST NAMES AND PHONE NUMBERS OF ANY OTHER PROFESSIONALS CONSULTED:

_____

_____

_____

_____