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OCCUPATIONAL THERAPY PEDIATRIC CASE HISTORY

Evaluation of your child will depend on information about his/her past history. Please complete this form as accurately as possible and avoid leaving blanks. You may feel free to put "unknown" or NA for "not applicable".

Person completing this form:____________________Relationship:________________

GENERAL INFORMATION

Child's Name __________________________Today's Date_____________________

Nickname_____________________________ Date of Birth_____________________

Address_______________________________Age____________________________

City/State/Zip___________________________Phone #________________________

Mother's Name_________________________ Work/Cell #_____________________

Father's Name__________________________Work/Cell #_____________________

Email Address____

Siblings (Names, Ages, M/F)____

Referred by____

Physician______________________________Physician's Phone/Fax______________

What language do you use to speak with your child?____________________________

Are there any other language spoken at home?________________________________

What language is your child most comfortable speaking?________________________

What language does your child understand best?______________________________

AREAS OF CONCERN

Please describe in detail why you are having your child seen for an occupational therapy evaluation? What are your primary concerns?

____
____
____
____
____
____

Is your child aware of the problem? Yes No

If yes, how does she/he feel about it?____

____

Have any other occupational therapists seen your child? Yes No

Who?__________________________________When?_____________________________

What were their conclusions or suggestions?____________________________________

____

Have any other specialists seen your child (i.e. physicians, psychologists, special education teachers, speech-language pathologists, physical therapists)? Yes No

If yes, what type of specialist(s)?____

When was the child seen?____

What were the specialist's conclusions or suggestions?_____________________________

____

____

OCCUPATIONAL PERFORMANCE

Self Care/Activities of Daily Living

Is your child able to independently complete the following dressing tasks? (Check mark all that apply)

Dress Self Undress Self Complete fasteners Tie Shoes

Is your child toilet trained? Yes No Comments __________________

Is your child able to independently complete the following hygiene tasks?

Wash hands Dry hands Bathe self Shower

Brush Teeth Brush Hair Blow Nose

Does your child help out at home? (put things away, cleaning, etc).

____

Does your child demonstrate any of the following difficulties with sleeping? (Check mark all that apply)

Falling asleep   Waking frequently in the night   Avoid bedtime

Difficulty waking   Night Terrors

Comments: ____

Fine Motor/Visual Motor

Hand preference: Right Left Unknown

Does your child show difficulty with object manipulation? (stacking blocks, puzzles, scissors, etc.)

____
____

Do you have any handwriting concerns?

____

Self Regulation/Attention/Sensory Processing

Does your child show sensitivity to certain sensations?

Tactile (paint, sand, clothing) ____

Sounds ____

Movement (swings, slides, rough and tumble play) ___________________________

Other ____

Does your child show difficulty with any of the following? (Check mark all that apply)

Calming/Soothing self   Distractible   Impulsive

Playing Independently   Changes in Routine   Hyperactivity

How does your child do with transitions? (moving from one activity to the next)

____
____

How do you feel your child's attention compares to other children his/her age?

Average   Short   Long

BIRTH/INFANCY HISTORY

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)

____

____

Length of pregnancy: Full Term Premature

Baby's weight at birth:________________________

Type of delivery: Head first Breech Planned Cesarean Emergency Cesarean

How long was labor?__________________Length of hospital stay_________________

Did your child experience any of the following? (Check mark all that apply)

Delayed cry Required oxygen Cord around neck Difficulty breathing

Jaundice Intubation Difficulty swallowing Difficulty sucking

Tube feeding Sleeping problems Colic

Other birth history facts you would like us to know about:_________________________

EARLY DEVELOPMENT (give approximate ages and comment on anything unusual)

Rolled over____________________ Sat alone__________ Crawled____________________

Walked alone__________________Toilet Trained_________First Words_____________

MEDICAL HISTORY

Medical Diagnosis (if any)____

Has your child had a hearing test?_______________ Date_______________________

Results____

Has your child had a vision test?_____________Date____________________________

Results____

Please list current medications____

Does your child have any assistive devices (glasses, orthotics, wheelchair, etc.)

____

Has your child had any of the following? If so, please explain and list dates, frequency, severity.

Significant Childhood Illnesses____

Surgeries____

Serious Injury____

Allergies____

Seizures____

Ear Infections____

Are there any pertinent family illnesses/medical conditions you would like us to know about?

____

FEEDING HISTORY

Does your child display any of the following? (Check mark all that apply)

Excessive Drooling Choking/gagging Difficulty Gaining Weight

Regurgitation of liquids/solids Reflux Difficulty Chewing/Swallowing

Do you consider your child to be a picky eater? _______If yes, please explain____

Does your child have food allergies?_______________________________________

What type of food is your child currently eating? (Check mark all that apply)

Liquids Pureed Pureed with lumps Ground

Mashed Easy Dissolvable (i.e. crackers or puffs) Table foods

How does your child eat? (Check mark all that apply)

Fingers Spoons Forks Breastfeeding Bottle

Sippy Cup Open Cup Straw

Where does your child typically eat? (living room, table, high chair, etc.)

____

How long does mealtime typically last? ______________________________

EDUCATIONAL HISTORY

Daycare/Playgroups/Preschool____

Grade________________Frequency_________Type of Classroom______________

Does your child have an Individualized Education Plan (IEP)?____________________

If so, what special education services is he/she receiving? ____________________

SOCIAL DEVELOPMENT

What is your child's favorite activity?____

What is your child's least favorite activity?____________________________________

Does your child play with other children?_______________________________________

Does your child demonstrate any repetitive or rigid behaviors?____________________

Does your child have excessive tantrums?_______________________________________

Is your child involved in extracurricular activities? (i.e. scouts, gymnastics, soccer, swim lessons, etc.)____

PLEASE LIST ANY ADDITIONAL INFORMATION THAT WOULD BE HELPFUL FOR THIS EVALUATION.____
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____
____
____
____

Thank you!

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