Mary Washington
PEDIATRIC THERAPY
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Occupational Therapy Case History

Today's Date:_____

Patient Name:_____ Date of Birth: _____/ _____ / _____

Person completing form: _____ Relationship to patient: _____

Who is accompanying the child to the evaluation? _____

Please check the reason(s) for evaluation

- ❑ Fine Motor
- ❑ Sensory
- ❑ Mobility
- ❑ Gross Motor
- ❑ Self Care Skills
- ❑ Handwriting
- ❑ Overactive
- ❑ Under-active
- ❑ Difficulty with transitions
- ❑ Difficulty following directions
- ❑ Difficulty with self regulation skills
- ❑ Difficulties with attending to tasks
- ❑ Difficulties with sitting at table for tasks for a reasonable length of time
- ❑ Have aversions to touch, sight, sounds, or smells
- ❑ Other

Describe your current concerns *(Please fill out this form as completely as possible).*

_____

_____

_____

Is there a language(s) other than English spoken in the home? ❑ yes ❑ no

If yes, which one(s) _____

Does the child speak the language? ❑ yes ❑ no

Does the child understand the language? ❑ yes ❑ no

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

Has your child received an Occupational Therapy Evaluation within the last 6 months? ❑ yes ❑ no

If yes, where and what were the results? (including school IEPs)_____

_____

_____

_____

Has your child received any other evaluation or therapy (physical therapy, counseling, vision, etc.)? ❑ yes ❑ no

If yes, please describe: _____

_____

_____

_____

Birth History

Was there anything unusual about the pregnancy or birth? ❑ yes ❑ no

If yes, please describe:

_____

_____

_____

_____

List any medications taken during pregnancy.

_____

_____

_____

_____

Was the mother sick during the pregnancy? ❑ yes ❑ no

If yes, please describe:

_____

_____

_____

_____

How old was the mother when the child was born? _____

Length of pregnancy in weeks: _____ **Birth weight** _____

Was the child able to go home with the mother? ❑ yes ❑ no

If no, please describe:

_____

_____

_____

_____

Medical History

Are immunizations up to date? ❑ yes ❑ no

Has your child had any of the following?

- ❑ Seizures
- ❑ Head injury
- ❑ Allergies
- ❑ Sinusitis
- ❑ Flu
- ❑ Breathing difficulties
- ❑ RSV
- ❑ High Fevers
- ❑ Colds
- ❑ Sleeping difficulties
- ❑ Snoring
- ❑ Drooling
- ❑ Thumb/finger sucking habit
- ❑ Tongue/lip tie
- ❑ Ear infections
- ❑ PE ear tubes
- ❑ Tonsillectomy
- ❑ Adenoidectomy
- ❑ GI issues/constipation issues
- ❑ Vision problems
- ❑ Hearing issues
- ❑ Other

List any allergies (medicine, food, pets, seasonal)

_____

_____

_____

List all medications/supplements and dosages that the child currently takes, including over the counter (i.e vitamins etc.)

_____

_____

_____

Any feeding issues as an infant or toddler (latching on, poor weight gain etc)?

_____

_____

_____

Is your child a picky eater, or have any feeding difficulties (pocketing food, choking/gagging)?

_____

_____

_____

Is your child currently (or recently) under a physician's care? ❑ yes ❑ no

If yes, why?

_____

_____

_____

Other important medical history:

_____

_____

_____

_____

_____

Developmental Milestones

What approximate age did your child achieve the following developmental milestones?

Crawl?
Age achieved in months: _____

Sit up?
Age achieved in months: _____

Walked?
Age achieved in months: _____

Fed Self?
Age achieved in months: _____

Dress self?
Age achieved in months: _____

Toileted?
Age achieved in months: _____

Current Skills

Does your child seem awkward, uncoordinated, or clumsy? ❑ yes ❑ no

Does your child lose their balance or fall easily? ❑ yes ❑ no

Your child currently communicates using… ❑ yes ❑ no

❑ Body language
❑ 2 to 4 word sentences
❑ Sounds (vowels, grunting)
❑ Sentences longer than four words
❑ Words (shoe, doggy, up)
❑ Other

Does your child display a hand preference? ❑ yes ❑ no

If so, which hand? ❑ Left ❑ Right ❑ Option3

Does your child currently…..*(check all that apply)*

❑ Repeat sounds, words or phrases over and over?
❑ Understand what you are saying?
❑ Retrieve/point to common objects upon request (ball, cup, shoe)?
❑ Follow simple directions ("Shut the door" or "Get your shoes")?
❑ Able to attend to self directed tasks?
❑ Able to attend to sit at a table to complete a task?
❑ Able to perform fine motor skills?

Choke on food or liquids? ❑ yes ❑ no ❑ N/A

Currently put toys/objects in his/her mouth? ❑ yes ❑ no ❑ N/A

Exhibit drooling? ❑ yes ❑ no ❑ Option3

Indicate any/all areas of difficulty:

❑ Zippers/Buttons
❑ Hopping/Jumping
❑ Handwriting
❑ Lacing/Tying Shoes
❑ Impulsivity
❑ Overly cautious
❑ Avoids getting messy
❑ Throwing ball overhand
❑ Walking/Running
❑ Walking up/down stairs
❑ Crossing midline
❑ Copying shapes
❑ Cutting Balance/Coordination
❑ Activity seeking
❑ Activity avoidance (i.e. swings, slides)
❑ Sensory Preferences/Avoidances (textures, sounds, light)
❑ Vision problems
❑ Using utensils
❑ Difficulty completing tasks
❑ Exhibits toe walking
❑ Other

Family Information

Who does the child live with (i.e. parents, siblings, grandparents)?

_____

Is there a family history of speech, language, or hearing difficulties or other diagnoses?

_____

Who and where does the child spend most of their time (i.e. parents, family, school, home)?

_____

What are your child's favorite items (i.e. toys, characters, food items, places to visit)?

_____

_____

_____

Educational History

Does your child attend school? ❑ yes ❑ no

If Yes, name of school:_____ Grade:_____

Does your child have an IEP from the public schools? ❑ yes ❑ no

Does your child receive any support services in school? (speech/occupational/physical therapy, tutoring, etc.) ❑ yes ❑ no

Has your child experienced any difficulties in school? ❑ yes ❑ no

If Yes, please explain:

_____

_____

_____

Behavioral Characteristics (check all that apply):

- ❑ Cooperative
- ❑ Attentive
- ❑ Willing to try new activities
- ❑ Easily distracted/short attention
- ❑ Plays alone for reasonable length of time
- ❑ Destructive/aggressive
- ❑ Separation difficulties
- ❑ Withdrawn
- ❑ Easily frustrated/impulsive
- ❑ Inappropriate behavior
- ❑ Stubborn
- ❑ Self-abusive behavior
- ❑ Restless
- ❑ Lack of appropriate eye contact

Additional information:

_____

_____

_____