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).*

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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)_____________________________

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

If yes, please describe: ____

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Birth History

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

If yes, please describe:

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List any medications taken during pregnancy.

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

If yes, please describe:

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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:

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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)

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

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

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

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

If yes, why?

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Other important medical history:

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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)?

____

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____

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:

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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:

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