Adults To Pediatrics Therapy, LLC

Rehabilitation Services

OCCUPATIONAL THERAPY CASE HISTORY FORM

IDENTIFYING AND FAMILY INFORMATION

Child's Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

_____

Mother's Name: _____ Address: _____

_____ _____

Daytime Phone: _____ Home: _____ Cell: _____

E-Mail: _____

Father's Name: _____ Address: _____

_____ _____

Daytime Phone: _____ Home: _____ Cell: _____

E-Mail: _____

Doctor's Name: _____ Phone: _____ Fax: _____

Child lives with:

☐ Birth Parents ☐ Foster Parents ☐ One Parent
☐ Adoptive Parents ☐ Parent and Step-Parent ☐ Other _____

Other Children in Family:

Name	Age	Sex	Grade	Diagnosis/Issues?

Child's Race/Ethnic Group

☐ Caucasian, Non-Hispanic ☐ Hispanic ☐ African-American
☐ Native American ☐ Asian or Pacific Islander ☐ Other _____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? _____
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? _____

STATEMENT OF THE PROBLEM

Describe in your own words what problem your child is having with motor development, sensory processing or behavior: _____

_____

_____

_____

_____

When did you first notice the problem? _____

_____

Who noticed the problem? _____

Does your child have a formal diagnosis? ☐ Yes ☐ No

If yes, what is it? _____

When was it made? _____

Who made the diagnosis? _____

Has your child received any other evaluation or therapy (e.g. physical therapy, counseling, occupational therapy, vision)? ☐ Yes ☐ No

If yes, please describe: _____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school? _____

_____

What are the goals for your child to be addressed through OT services? _____

_____

BIRTH HISTORY

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe: _____

_____

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

Was the mother sick during the pregnancy? ☐ Yes ☐ No

If yes, please describe: _____

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If the child stayed at the hospital, please describe why and how long he/she stayed: _____

MEDICAL HISTORY

Has your child ever had any of the following?

- ☐ adenoidectomy
- ☐ allergies
- ☐ breathing difficulties
- ☐ chicken pox
- ☐ colds
- ☐ ear infections
  How Often? _____
- ☐ ear tubes
- ☐ encephalitis
- ☐ flu
- ☐ head injury
- ☐ high fevers
- ☐ measles
- ☐ meningitis
- ☐ mumps
- ☐ scarlet fever
- ☐ seizures
- ☐ sinusitis
- ☐ sleeping difficulties
- ☐ thumb/finger sucking habit
- ☐ tonsillectomy
- ☐ tonsillitis
- ☐ vision problems

Other serious injury/surgery: _____

Does your child have any medical diagnosis? ☐ Yes ☐ No

If yes, please specify: _____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why? _____

Please list any medications your child takes regularly: _____

DEVELOPMENTAL HISTORY

Please tell the approximate age your child achieved the following developmental milestones. Please comment if any were skipped or not yet achieved. Some may not be applicable to your child yet.

- _____ hold head up
- _____ roll over both directions
- _____ stood
- _____ sat alone
- _____ babbled
- _____ put two words together
- _____ ran
- _____ eat solid foods
- _____ reached for object
- _____ crawl on hands/knees
- _____ walked unaided
- _____ grasped crayon/pencil
- _____ said first words
- _____ spoke in short sentences
- _____ toilet trained
- _____ cruise around furniture

_____ spoon-fed independently
_____ button/zip independently
_____ ride bike (no training wheels)
_____ demonstrate a hand preference, right or left
_____ Did your child start talking then stop or lose words?

_____ drink from open cup
_____ ride tricycle
_____ dress independently

Please comment if there was anything that contributed to a delay in one of the above milestones:

_____

Does your child:

- ☐ use utensils?
- ☐ use straw?
- ☐ drool? If yes, when? _____ _____
- ☐ self-feed?
- ☐ need assistance with feeding?
- ☐ brush his/her teeth
- ☐ allow brushing?
- ☐ use cup?
- ☐ chew well?
- ☐ have difficulty falling asleep?
- ☐ stay asleep?

Can your child do any of the following independently?

- ☐ Button
- ☐ Zip
- ☐ Put on jacket
- ☐ Put on pants
- ☐ Put on socks
- ☐ Put on shoes
- ☐ tie shoes

Does/is your child:

- ☐ like baths?
- ☐ like swings?
- ☐ like rough-housing?
- ☐ like stuffed animals?
- ☐ sensitive to loud sounds?
- ☐ sensitive to bright lights?

SENSORY MOTOR HISTORY

TACTILE (TOUCH) SENSORY SYSTEM

Does your child:

1.	Mind being touched by others?	☐ Yes	☐ No
2.	Startle to being touched unexpectedly (i.e. if someone accidentally brushes against them?)	☐ Yes	☐ No
3.	Always have to have their hands clean?	☐ Yes	☐ No
4.	Prefer to initiate cuddling or hugging?	☐ Yes	☐ No
5.	Mind getting messy/dirty (i.e. playing in sand, finger painting, glue, etc)?	☐ Yes	☐ No
6.	Dislike going barefoot? (is it on certain surfaces such as grass/sand?)	☐ Yes	☐ No
7.	Avoid certain textures of clothing (i.e. jeans, sweaters, tight materials etc)	☐ Yes	☐ No
8.	Dislike grooming activities, such as washing face, brushing hair, hair cut, nails cut, etc.?	☐ Yes	☐ No
9.	9. Seem to lack an awareness of touch?	☐ Yes	☐ No
10.	Seem to have a need to touch everything/everyone around them?	☐ Yes	☐ No
11.	Crave touch from others?	☐ Yes	☐ No
12.	Appear to have an abnormally high/low pain tolerance?	☐ Yes	☐ No

VISUAL SENSORY SYSTEM

Does your child:

1.	Stare or look at an object longer than expected?	☐ Yes	☐ No
2.	Seem sensitive to bright lights?	☐ Yes	☐ No
3.	Tilt their head to the side when looking at an object, reading or writing?	☐ Yes	☐ No
4.	Rub or squint their eyes when looking at something?	☐ Yes	☐ No
5.	Have difficulty identifying colors?	☐ Yes	☐ No
6.	Have difficulty discriminating between size/shape of an object?	☐ Yes	☐ No
7.	Dislike closing or covering their eyes?	☐ Yes	☐ No
8.	Have difficulty with puzzles?	☐ Yes	☐ No
9.	Skip lines when reading or writing?	☐ Yes	☐ No

AUDITORY SENSORY SYSTEM

Does/is your child:

1.	Respond negatively to unexpected or loud noises (i.e. cover ears, run away, become upset, cry, etc.)?	☐ Yes	☐ No
2.	Tend to notice sounds that others don't notice?	☐ Yes	☐ No
3.	Ask for the TV or radio to be lowered?	☐ Yes	☐ No
4.	Become upset (i.e. cover ears, cry, ask to leave) in a noisy setting?	☐ Yes	☐ No
5.	Distracted easily by background noises?	☐ Yes	☐ No
6.	Appear to make noises just to hear themselves?	☐ Yes	☐ No
7.	Consistently respond to their name being called?	☐ Yes	☐ No
8.	Appear not to hear what you say?	☐ Yes	☐ No

PROPRIOCEPTIVE SYSTEM (BODY AWARENESS)

Does your child:

1.	Crave jumping or falling into objects/people?	☐ Yes	☐ No
2.	Seem to do things either too hard or too light (using either too little or too much muscle force)?	☐ Yes	☐ No
3.	Appear to grasp objects either too hard or too light?	☐ Yes	☐ No
4.	Play overly rough with others?	☐ Yes	☐ No
5.	Seem unaware of how to move their body to do a motor task?	☐ Yes	☐ No
6.	Crave hugging and/or cuddling?	☐ Yes	☐ No
7.	Crave rough play?	☐ Yes	☐ No
8.	Walk into other people/objects/walls?	☐ Yes	☐ No

VESTIBULAR SYSTEM (MOVING BODY IN SPACE)

Does/is your child:

1.	Fall frequently or lose their balance easily?	☐ Yes	☐ No
2.	Overly cautious on playground equipment or with motor activities?	☐ Yes	☐ No
3.	Seem uncomfortable moving in space (i.e. lifting feed off of ground, stairs, heights)?	☐ Yes	☐ No
4.	Get carsick easily?	☐ Yes	☐ No
5.	Get nauseous and/or vomit from movement (i.e. carnival rides, swinging)?	☐ Yes	☐ No

6. Dislike swinging or carnival rides?	☐ Yes	☐ No
7. Dislikes spinning, bouncing and twirling?	☐ Yes	☐ No
8. Dislike tipping head backwards?	☐ Yes	☐ No
9. Have trouble catching self when falling?	☐ Yes	☐ No
10. Like to climb high and lack safety awareness?	☐ Yes	☐ No
11. Seem to spin and move around more than others?	☐ Yes	☐ No
12. Seem not to get dizzy as much as peers?	☐ Yes	☐ No
13. In constant motion, have difficulty sitting still?	☐ Yes	☐ No

POSTURAL CONTROL

Does/is your child:

1. Have difficulty sitting upright on the floor?	☐ Yes	☐ No
2. Lean on objects or people when standing up?	☐ Yes	☐ No
3. Slump or hold their head in their hand when sitting at a desk/table?	☐ Yes	☐ No
4. Seem weaker than peers?	☐ Yes	☐ No
5. Tire easily with motor tasks/poor endurance?	☐ Yes	☐ No
6. Prefer more sedentary activities rather than playing outside?	☐ Yes	☐ No

ORAL MOTOR

Does/is your child:

1. Crave certain textures of food (i.e. crunchy, soft, chewy, etc)? Please specify: _____	☐ Yes	☐ No
2. Crave certain flavors of food (i.e. sweet, salty sour, etc? Please specify: _____	☐ Yes	☐ No
3. Have a history of reflux?	☐ Yes	☐ No
4. Gag when eating certain foods or food textures?	☐ Yes	☐ No
5. Chew on non-food objects?	☐ Yes	☐ No
6. Use a pacifier or suck their thumb?	☐ Yes	☐ No
7. Become upset or sensitive to teeth brushing?	☐ Yes	☐ No
8. Require a special diet?	☐ Yes	☐ No
9. Have any feeding problems?	☐ Yes	☐ No

GROSS MOTOR SKILLS/MOTOR PLANNING

Does/is your child:

1. Have slow and deliberate movements with motor activities?	☐ Yes	☐ No
2. Move too fast and lose control?	☐ Yes	☐ No
3. Appear clumsy or awkward?	☐ Yes	☐ No
4. Have trouble getting themselves dressed?	☐ Yes	☐ No
5. Enjoy P.E. and sports?	☐ Yes	☐ No
6. Have difficulty jumping or running?	☐ Yes	☐ No
7. Have difficulty learning new motor skills?	☐ Yes	☐ No
8. Able to jump on one foot?	☐ Yes	☐ No
9. Have difficulty kicking a ball?	☐ Yes	☐ No
10. Have difficulty catching and throwing a ball?	☐ Yes	☐ No

FINE MOTOR SKILLS

Does/is your child:

1. Have difficulty with buttons, zippers or snaps?	☐ Yes	☐ No
2. Have difficulty manipulating small toys?	☐ Yes	☐ No
3. Have difficulty holding a pencil?	☐ Yes	☐ No
4. Able to identify left and right hands?	☐ Yes	☐ No
5. Have difficulty copying shapes or drawing?	☐ Yes	☐ No
6. Have difficulty coloring within the lines?	☐ Yes	☐ No
7. Able to write along a line?	☐ Yes	☐ No
8. Reverse letters when writing?	☐ Yes	☐ No
9. Skip lines when copying a writing sample?	☐ Yes	☐ No
10. Have difficulty with spacing and sizing letters?	☐ Yes	☐ No
11. Complaining of being tired when writing?	☐ Yes	☐ No
12. Frustrate easily when writing?	☐ Yes	☐ No

BEHAVIOR HISTORY

Behavioral Characteristics:

☐ Cooperative	☐ Restless	☐ Low self-esteem
☐ Attentive	☐ Poor eye contact	☐ Sleeps well
☐ Willing to try new activities	☐ Good eye contact	☐ Prefers to play alone
☐ Plays alone for reasonable length of time	☐ Destructive/aggressive	☐ Poor sleeper
☐ Separation difficulties	☐ Withdrawn	☐ happy
☐ Easily frustrated	☐ Inappropriate behavior	☐ Affectionate
☐ Stubborn	☐ Self –abusive behavior	☐ Flexible
☐ Friendly	☐ Inattentive	☐ Cries easily
☐ Echoes words spoken to them	☐ Easy-going	☐ Makes friends easily
☐ Prefers socializing with adults	☐ Passive	☐ Shy
☐ Easily distracted/short attention	☐ High activity level	☐ Acts out
☐ Socially awkward	☐ social	☐ Impulsive

SCHOOL HISTORY

If your child is in school, please answer the following:

Name of daycare/school and grade in school: _____

Teacher's Name: _____

Has your child repeated a grade? _____

What are your child's strengths and/or best subjects? _____

_____

Is your child having difficulty with any subjects? _____

_____

Is your child receiving help in any subjects? _____

Additional Comments