Adults To Pediatrics Therapy, LLC
Rehabilitation Services

OCCUPATIONAL THERAPY PEDIATRIC 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
________________ reached for object
________________ crawl on hands/knees
________________ walked unaided
________________ grasped crayon/pencil
________________ said first words
________________ spoke in short sentences

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______________	ran	______________	toilet trained
______________	eat solid foods	______________	cruise around furniture
______________	spoon-fed independently	______________	drink from open cup
______________	button/zip independently	______________	ride tricycle
______________	ride bike (no training wheels)	______________	dress independently
______________	demonstrate a hand preference, right or left		
______________	Did your child start talking then stop or lose words?		

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

Does/is your child:

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

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, ☐ Yes ☐ No

stairs, heights)?

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)? ☐ Yes ☐ No
   Please specify: ____
2. Crave certain flavors of food (i.e. sweet, salty sour, etc? ☐ Yes ☐ No
   Please specify: ____
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:

Question	Yes	No
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

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