OCCUPATIONAL THERAPY CASE HISTORY

Please fill out this form as completely as possible.

Person completing form ___________________________________ Relationship to patient_____________________________________

Who is accompanying the child to the evaluation?________________________________________________________

Patient Name ________________________________________________________________________________

PLEASE CHECK THE REASON(S) FOR EVALUATION:

☐ Fine Motor  ☐ Sensory  ☐ Mobility  ☐ Gross Motor  ☐ Self Care Skills  ☐ Handwriting  ☐ Overactive

☐ Underactive  ☐ 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:

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

When did you first notice your child’s difficulty?

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

Describe any problems that appear to a result of your child’s difficulty?

_______________________________________________________________________________________________________________

_______________________________________________________________________________________________________________

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**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If yes, please describe.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was there anything unusual about the pregnancy or birth?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>List any medications taken during pregnancy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the mother sick during the pregnancy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How old was the mother when the child was born?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of pregnancy in weeks:</td>
<td></td>
<td></td>
<td>Birth weight:</td>
</tr>
<tr>
<td>Was the child able to go home with the mother?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY**

<table>
<thead>
<tr>
<th>Question</th>
<th>□ yes</th>
<th>□ no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are immunizations up to date?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child had any of the following?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adenoidectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinusitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathing difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken pox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High fevers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thumb/finger sucking habit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear infections (How many? ________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE ear tubes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RSV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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?

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Age achieved</th>
<th>N/A</th>
<th>Milestone</th>
<th>Age achieved</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crawl?</td>
<td></td>
<td>N/A</td>
<td>Toilett trained?</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Sat alone?</td>
<td></td>
<td>N/A</td>
<td>Said first words?</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Stood?</td>
<td></td>
<td>N/A</td>
<td>Put two words together?</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Walked?</td>
<td></td>
<td>N/A</td>
<td>Grasp crayon/pencil?</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Fed Self?</td>
<td></td>
<td>N/A</td>
<td>Dress self?</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

## 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…

- ☐ body language
- ☐ sounds (vowels, grunting)
- ☐ words (shoe, doggy, up)
- ☐ 2 to 4 word sentences
- ☐ sentences longer than four words
- ☐ other ______________________

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

If so, which hand?  
☐ right  ☐ left

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?

Does your child...

- ☐ Choke on food or liquids?  
  ☐ yes  ☐ no  ☐ N/A
- ☐ Currently put toys/objects in his/her mouth?  
  ☐ yes  ☐ no  ☐ N/A
- ☐ Brush his/her teeth and/or allow brushing?  
  ☐ yes  ☐ no  ☐ N/A
- ☐ Exhibit drooling?  
  ☐ yes  ☐ no  ☐ N/A

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 gross, fine motor or other 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: __________________________
How many days and hours per week __________________________________________

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  
- □ willing to try new activities  
- □ plays alone for reasonable length of time  
- □ separation difficulties  
- □ easily frustrated/impulsive  
- □ stubborn  
- □ restless  
- □ attentive  
- □ easily distracted/short attention  
- □ destructive/aggressive  
- □ withdrawn  
- □ inappropriate behavior  
- □ self-abusive behavior  
- □ lack of appropriate eye contact

**ADDITIONAL INFORMATION**

PLEASE PROVIDE US WITH ANY ADDITIONAL INFORMATION THAT YOU WOULD LIKE US TO KNOW...
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

**THANK YOU!**