MONKEY MOUTHS

pediatric therapy

Occupational Therapy Child History Form

Date:____

Child's Name:____

Child's Age: ________________________

Date of Birth:____

Parent's Name:____

Phone: (Home)_____________________(Work)_______________________________

Email:____

Emergency Contact:____

Child's Address:____

Child's Doctor:____

Sisters and Brothers in the household:

Name: Age:

____

____

____

____

Name of the person completing this form:__________________________________

Relationship to child:____

STATEMENT OF THE PROBLEM:

Reason for referral:

____

____

____

Describe the problem:

____

____

____

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Is this the first OT evaluation for your child? Yes No

If not, who else has seen this child? (Who , When, Outcome)

____

____

____

What skills do you hope your child will gain if therapy is warranted? What does your child want to learn to do that they currently can't?

____

____

____

MEDICAL HISTORY:

Were there any problems during pregnancy, birth or delivery? Yes No

If so, please explain:

____

____

____

Was your child born prematurely? Yes No

If yes, at how many weeks? ____

Is there any history of medical concerns? Yes No

Please describe any medical concerns, injuries, illnesses, or surgeries:

____

____

____

____

Has hearing been tested? Yes No

Where?____

When?____

Results____

____

6168 Bentridge Drive
Hurst, TX 76054

370 S State Hwy 121 N.
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Coppell, TX 75019

7217 Hawkins View Dr.
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Southlake, TX 76092

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Has vision been tested? Yes No

Wears Glasses: Yes No

Where? ____

When? ____

Results____

____

Please list any medications your child is currently taking:

____

____

____

____

DEVELOPMENTAL MILESTONES

Age child began to roll: ____________________________

Age child sat unsupported: __________________________

Age child walk / ran: _____________________________

Age child began to ride a tricycle/bike: __________________________

Age child began to feed themselves finger foods: _________________________

Age child began to use feeding utensils:______________________________

Age child began to use writing utensils (colors/pencils)____________________

Briefly describe your child's ability to:

Participate in age level self-care skills (items can include dressing, feeding, grooming, buttons and shoe tying):____

____

____

Participate in age level eye-hand coordination tasks (items can include sports participation, handwriting abilities and scissoring):____

____

____

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Participate in school related activities (reading, spelling, math):____________________________
____
____

Any current school environment modifications? ______________________________________
____

Briefly describe any behavior problems:____
____
____
____

Briefly describe any fine motor concerns:____
____
____

Briefly describe any gross motor concerns:____
____
____

Has your child been evaluated by other professionals (i.e. Speech Therapy, Physical Therapy, Psychology, etc.)? Yes No
If so, please explain:
____
____
____

INTEREST INVENTORY:
What are your child's interests and favorite activities?
____
____
____

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Does your child have any fears or sensitivities to sensory stimuli (i.e. lights, loud noises, textures)?

____

____

Does your child receive special help in school? Yes No
If so, please explain:

____

____

____

Is there anything else you wish to add that would help insure a positive testing experience for your child?

____

____

____

____

Is there any additional information or concerns that would help us to get to know your child better?

____

____

____

____

Thank you very much for your help and for the information you provided in this case history form. If you have questions before your intake or diagnostic appointments, please contact us at (817) 479-7019.

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