Occupational Therapy Case History

Patient and Family Information

Child's Name: _____ Birth date: _____ ◯M ◯F
Mother's Name: _____ Daytime Phone: _____
Father's Name: _____ Cell Phone: _____

Primary language spoken in the home: ◯English ◯Spanish ◯Other _____
What are your concerns/what have others told you about your child's fine motor, gross motor, and sensory processing skills?

_____

Birth History

Mother's health during pregnancy: ◯Good ◯Fair ◯Poor Describe

_____

History of alcohol and/or drug abuse during pregnancy: ◯Yes ◯No Describe

_____

Length of Pregnancy _____Child's Birth Weight_____
Problems during or after delivery:

_____

Did the child go home with his/her mother from the hospital? ◯Yes ◯No
If no, please describe why and how long:

_____

Medical History

Please list any current or previous diagnoses:

_____

Medications your child takes regularly:

_____

Has your child taken the prescribed dosage today? ◯Yes ◯No

Allergies to food or medication:

_____

Has your child ever been hospitalized, had a serious accident, or had an operation:

_____

Additional medical information:

_____

_____

Developmental History

Please list the approximate age your child achieved the following milestones:

_____ Roll over _____ Crawl
_____ Sit independently _____ Pull to stand
_____ Walk alone _____Learn to Climb
_____Pedal a tricycle

Does your child have problems with:
Balance _☐_ Coordination__☐__

Do you have any current concerns about your child's gross motor skills? _☐__
If yes, please explain:

_____
_____

Do you currently have concerns about your child's fine motor skills? _☐_
If yes, please explain:

_____
_____

Can your child: Button _☐_ Snap _☐_ Zip_☐_
Does your child: Color easily_☐_ Write neatly _☐_

Does your child have difficulty with:
Using scissors _☐_ Grip_☐_ Fasteners_☐_ Handwriting_☐_

School History

Is your child in a school/daycare? ○ Yes ○ No Name of school/daycare:

_____

Grade: _____ Does your child have an IEP? ○ Yes ○ No
What (if any) services are your child receiving through school?

_____

Occupational Therapy History

Has he/she received early intervention (TEIS/BCW) services in the past/been tested? ○ Yes ○ No
Has he/she ever had a speech evaluation/screening? ○ Yes ○ No
If yes, where and when?

_____

What were you told?

_____

Has your child ever had occupational therapy? ○ Yes ○ No If yes, where and when?_____
What was he/she working on?

_____

Has your child received/currently receiving any other therapy? ☐ physical therapy
☐ occupational therapy ☐ counseling ☐ vision ☐ other _____

Is your child aware of, or frustrated by, any current difficulties, fine motor, gross motor, or sensory? ◯Yes ◯No

If yes, please explain:

_____

_____

Self Care

At what age was your child:

Able to dress alone _____ Able to bathe alone _____ Bladder trained_____

Bowel Trained _____ Dry at night_____ Tying Shoelaces _____

Feeding

Does your child currently have problems with (check all that apply):

Self feeding with _☐_ hands, _☐_ with utensils?

Chewing_☐_ Food textures_☐_ Limited food preferences _☐_

Poor appetite _☐_ Sitting for completion of meal _☐_ Swallowing_☐_

Is your child's normal diet well balanced? _◯_Yes _◯_No

What are your child's preferred foods?

_____

Described other eating problems or unusual habits/preferences:

_____

Sensory: (Check all that apply, and explain if necessary)

Sense of Touch:

Avoids some kinds of touch _☐_

Seeks out some kinds of touch _☐_

No Problems _☐_

Explain as necessary:

_____

_____

Oral:

Avoids some mouth sensations_☐_

Seeks some mouth sensations_☐_

No Problems_☐_

Explain as necessary:

_____

_____

Hearing:

Hypersensitive to some sound_☐_
Ignores some sounds _☐_
Inconsistent response to sound_☐_
No problems_☐_
Explain as necessary:

_____
_____

Olfactory:

Avoids some smells_☐_
Seeks some smells_☐_
Atypical/odd smelling behavior_☐_
No problems_☐_
Explain as necessary:

_____
_____

Vision:

Difficulty with tracking or depth perception_☐_
Over-focusing _☐_
Atypical or odd visual behavior_☐_
No problems_☐_
Explain as necessary:

_____
_____

Vestibular/Proprioceptive:

Avoids some movement/posture_☐_
Seeks out some movement/posture_☐_
No Problems_☐_
Explain as necessary:

_____
_____

Pain Threshold:

Higher than expected_☐_
Lower than expected_☐_
Inconsistent _☐_
No Problems_☐_
Seeks out comfort for injury/pain: Yes_◯_ No _◯_
Explain as necessary:

_____
_____

Social History:
Your child's favorite toys:
_____

Play skills: ☐ Prefers to play alone ☐ Plays well with other children his/her age ☐ Excessive shyness/clinging to caregiver ☐ Limited initiation of social contact ☐ Social anxiety ☐ Difficulty maintaining social interaction ☐ Peer conflict ☐ Difficulty showing emotion

Please describe your child's social skills:
_____
_____

Additional comments/concerns regarding your child:
_____
_____