Skill Builders

Speech Language and Occupational Therapy Services

OT Case History Form

Person completing this form: ___________________________________ Date:________________

Relationship to child: ____

Insurance carrier: ___________________________________Referral

Source:__________________________

PATIENT INFORMATION

Child's name: _______________________________ Date of Birth:____________________
Address:____
Male / Female Age:________ Grade:_____________

FAMILY INFORMATION

Mother's name:_______________________________ Date of Birth:___________________
Occupation:___________________________ Work phone:__________________________
Address: ____

Father's name:_______________________________ Date of Birth:___________________
Occupation:___________________________ Work Phone:__________________________
Address: ____

Sibling(s): ____________________________ Age:________________
____________________________ Age:________________
____________________________ Age:________________

Developmental and Medical History for Occupational Therapy

Briefly describe why you are pursuing an occupational therapy evaluation for your child:

____

Please circle the answers which best describe your child. Please add any remarks or comments that you feel may be helpful, including your child's strengths. This information is vital to our evaluation process—your observations give us details about day-to-day life, and so, help us to interpret our test findings with greater accuracy. Thank you for your time.

Before Birth:		**Remarks:**
1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operations, or any other medical difficulties?	YES NO	
2. Were there any drugs, medications, alcohol, or cigarettes used during pregnancy?	YES NO	
3. If adopted, provide the date and age when the child arrived at your home. Please specify any known details of care before adoption.	DATE__________ AGE___________	
Delivery:		
1. Was the delivery premature?	YES NO	
2. Was medication given to induce labor or during labor? Please specify.	YES NO	
3. Was the labor abnormal? (prolonged, short) Please specify.	YES NO	
4. Was it an unusual delivery? (i.e. breech, Caesarean, forceps) Please specify.	YES NO	
5. What was the baby's gestational age (weeks) and birth weight?	AGE:_______weeks WEIGHT:_______lbs.	

Birth: **Remarks:**

Question	Response	Remarks
1. Was the baby alert with normal muscle tone and color at birth?	YES NO	
2. Were there medical complications at birth affecting heart, lungs, kidneys, or digestive organs? Please explain.	YES NO	
3. Were there any congenital defects affecting the limbs, face, nerves, other body parts? Please explain.	YES NO	
4. Were there complications such as: cyanosis, jaundice, or limpness? Please specify.	YES NO	
5. Was there a need for oxygen, transfusions, IV, or tube feedings?	YES NO	
6. Did the baby spend extra time at the hospital or time in a special nursery?	YES NO	
7. Was the baby bottle or breast-fed? Please circle.	BOTTLE BREAST-FED	
8. Were there any feeding complications? Please specify.	YES NO	

Medical History Since Newborn Period: **Remarks:**

Question	YES	NO	Remarks
1. Are your child's immunizations up to date for the following:			
a. Measles, Mumps, & Rubella	YES	NO	
b. Chicken Pox	YES	NO	
c. Diphtheria, Pertussis, & Tetanus	YES	NO	
d. Polio	YES	NO	
e. Hepatitis B	YES	NO	
2. Describe any significant adverse reaction to vaccines.			

3. Circle any serious illnesses she/he has had and give dates & current status.	Dates:	Remarks:
a. Meningitis b. High Fevers c. Scarlet Fever d. Diabetes e. Seizures (dates, how often, type?) f. Respiratory, stomach, kidney, liver, or heart problems g. Any allergies (Please specify) h. Tuberculosis i. Polio j. Physical injuries k. Malnutrition l. Frequent ear infections/tubes m. Surgeries n. Others, please list:		
4. Has your child had vision and hearing exams? Circle & list dates, by whom, & results. a. Vision b. Hearing	Dates:	Whom & Results:
5. Is your child currently on medication? Please give names and reasons.	YES NO	Names & Reasons:
Developmental History At what ages did your child meet these motor milestones? Please note those that were skipped or not yet achieved.	Age:	Comments/Clarifications:
1. roll over both ways		
2. sit independently		
3. crawl on hands and knees		
4. cruise around furniture		
5. walk independently		
6. speak first word		
7. drink from a cup without a lid independently		
8. use a spoon independently		
9. demonstrate hand preference		Circle: Left handed/Right handed
10. put on shirt independently		
11. button independently		
12. dress independently		

	Age:	Comments/Clarifications:
13. ride a tricycle		
14. ride a bicycle without training wheels		
15. pump a swing		
16. learn to tie shoelaces		

Describe your child as an infant:

1. good, non-demanding	YES	NO
2. cried a lot, fussy, irritable	YES	NO
3. was alert	YES	NO
4. was active	YES	NO
5. was passive	YES	NO
6. liked being held	YES	NO
7. liked being rocked	YES	NO
8. was tense when held	YES	NO
9. was floppy when held	YES	NO
10. slept through the night easily	YES	NO
11. had irregular sleep patterns	YES	NO

Describe your child at present:

1. mostly quiet	YES	NO
2. talks constantly	YES	NO
3. overly active	YES	NO
4. tires easily	YES	NO
5. impulsive	YES	NO
6. restless	YES	NO
7. stubborn	YES	NO
8. resistant to changes	YES	NO
9. over-reacts	YES	NO
10. fights frequently	YES	NO
11. often happy	YES	NO
12. frequent temper tantrums	YES	NO
13. falls often	YES	NO
14. clumsy	YES	NO

Comments/Clarifications:

15. has difficulty separating from primary caregiver	YES	NO
16. wanders off without caution	YES	NO
17. has nervous habits or tics (Please specify)	YES	NO
Describe your child at present:		
18. wets bed	YES	NO
19. poor attention span	YES	NO
20. easily frustrated	YES	NO
21. has unusual fears (Describe)	YES	NO
22. rocks self during activities (Describe)	YES	NO
23. bangs head on purpose	YES	NO
24. has difficulty learning new tasks (i.e. bike riding, drawing/writing, throwing a ball, etc.)	YES	NO

SENSORY HISTORY

1. AUDITORY/HEARING/LANGUAGE.

Does your child:

a. respond negatively in response to unexpected or loud noises?(e.g. covering ears, running away, startling, or becoming distressed)	NO	YES
b. become bothered by household sounds such as a vacuum cleaner, hair dryer, dishwasher?	NO	YES
c. have difficulty paying attention when there are noises nearby?	NO	YES
d. tune into sounds that other people tend not to notice? (e.g. clocks ticking, refrigerators)	NO	YES
e. ask others not to talk, sing, or make noise?	NO	YES
f. enjoy singing and dancing to music?	NO	YES
g. seem confused about the direction from which sounds are coming?	NO	YES
h. appear to make noise for noise's sake?	NO	YES
i. appear not to hear some sounds?	NO	YES
j. appear hard of hearing?	NO	YES

Language skills

Comments/Clarifications:

k. have difficulty understanding phrases, directions, or stories other children her/his age can follow?	NO	YES
l. Did your child start to talk and then stop or lose a number of words?	NO	YES
m.Does your child sometimes repeat phrases from books or videos rather than composing his/her own sentences to play or make requests?	NO	YES
n. Does your child often “echo” phrases back to you?	NO	YES

2. VISUAL SYSTEM. Does your child:

a. maintain his/her visual focus on a task or object less than is expected?	NO	YES
b. rub his/her eyes, turn her/his head to the side, or squint when trying to read or look at objects closely?	NO	YES
c. have difficulty naming, discriminating, or matching colors, shapes or sizes?	NO	YES
d. show sensitivity to bright light, fluorescent lighting?	NO	YES

3. VESTIBULAR SYSTEM (of the inner ear, for balance and sense of motion). Does your child:

a. seem to twirl and spin more than others?	NO	YES
b. like to climb very high?	NO	YES
c. like fast carnival rides, merry go-rounds?	NO	YES
d. seem not to get dizzy when others usually do?	NO	YES
e. seem not as strong as peers?	NO	YES
f. frequently like to be inverted, tipped upside down, hang upside down, or enjoy doing lots of somersaults?	NO	YES
g. have trouble catching self when falling?	NO	YES
h. fall for no apparent reason?	NO	YES
i. have difficulty balancing?	NO	YES
j. seem fearful of movement as in going up and down stairs, moving on playground equipment?	NO	YES

Does your child:

Comments/Clarifications:

k. dislike being tossed in the air?	NO	YES	
l. dislike merry-go-rounds?	NO	YES	
m. dislike spinning & twirling?	NO	YES	
n. prefer to play in the house rather than at the playground with other children?	NO	YES	
o. get carsick?	NO	YES	
p. seem uncomfortable moving in space? (on open soccer field, crawling through small spaces, climbing, etc.)	NO	YES	
q. seem fearful of heights?	NO	YES	
r. resist balance activities?	NO	YES	
s. dislike swinging, being bounced on adult's lap as a young child?	NO	YES	

4. TACTILE SYSTEM/TOUCH. Does your child:

a. dislike going barefoot, insist on always wearing shoes &/or socks?	NO	YES	
b. pull away from light touch?	NO	YES	
c. seem excessively ticklish?	NO	YES	
d. startle or over-react to being touched unexpectedly?	NO	YES	
e. only accept touch from people he/she knows well?	NO	YES	
f. object to being touched by familiar people?	NO	YES	
g. stand or sit away from a group when with other children?	NO	YES	
h. avoid finger feeding him/herself messy foods?	NO	YES	
i. dislike many foods due to their textures (meats, crunchy snacks, soft smooth foods, mixed textures)? Please describe preferred textures.	NO	YES	
j. want to have hands clean at all times?	NO	YES	
k. avoid playing with messy things such as finger paint, sand, glue, glitter, or clay?	NO	YES	
l. show a dislike for typical grooming activities such as having teeth brushed, face washed, hair brushed, haircut, or nails cut? Please circle any that apply.	NO	YES	

Does your child:			Comments/Clarifications:
m. avoid certain textures of clothing such as fuzzy sweaters, woven shirts?	NO	YES	
n. prefer to wear long sleeves or pant legs regardless of weather?	NO	YES	
o. frequently pull down or push up long sleeves or pant legs?	NO	YES	
p. complain that bed sheets are too rough?	NO	YES	
q. prefer to touch rather than be touched?	NO	YES	
r. hurt others by pushing, bumping, pinching, and/or biting?	NO	YES	
s. isolate him/herself from other children?	NO	YES	
t. Struggle against being held or cuddled?	NO	YES	
u. Seem to lack the normal awareness of touch? (i.e. doesn't seem to notice food around mouth or face; clothes/socks are twisted).	NO	YES	
v. seem driven to touch things more than others of the same age?	NO	YES	
w. Crave touch from others?	NO	YES	
x. Feel pain MORE than others?	NO	YES	
y. Feel pain LESS than others?	NO	YES	

5. PROPRIOCEPTIVE SYSTEM (sensations from joints, muscles, and tendons).
Does your child:

a. grasp objects very tightly, write with heavy pressure, or slam doors?	NO	YES
b. grind her/his teeth?	NO	YES
c. seem driven to push, pull, drag, lift, or drop heavy objects?	NO	YES
d. seem driven to jump, crash into objects and people?	NO	YES
e. tend to break toys more than other children?	NO	YES
f. chew on nonfood objects?	NO	YES
g. use too much force when playing with others?	NO	YES

		Comments/Clarifications
h. crave hugging or rough play?	NO YES	
i. have difficulty sitting erect, prefer to lie on the floor than sit for extended periods, tire easily in one body position?	NO YES	
j. seem unsure how far to raise or lower body during movements such as sitting down or stepping over an object?	NO YES	
k. seem generally weak?	NO YES	
l. hold objects too loosely to use them effectively?	NO YES	
m. have poor motor coordination with small objects (e.g. pencils, buttons)?	NO YES	

6. GUSTATORY/OLFACTORY SYSTEM
(taste and smell) Does your child:

a. respond to odors that others don't notice?	NO YES
b. have a history of resisting new flavors or textures?	NO YES
c. like to taste non-food items such as glue or play dough?	NO YES
d. explore objects by smell?	NO YES
e. seem unaware of typical odors and scents?	NO YES
f. react negatively to smells?	NO YES
g. gag or complain of nausea when smelling odors that don't bother others?	NO YES
h. chew on non-food objects?	NO YES
i. have unusual cravings for: salt, sour, bitter, sweet? Circle all that apply.	NO YES
j. act as though all food tastes the same?	NO YES
k. have trouble with constipation?	NO YES
l. have trouble learning urinary control?	NO YES
m. have trouble learning bowel control?	NO YES
n. Is your child toilet trained?	NO YES
o. have a history of reflux? Is medication needed?	NO YES

6. MOTOR DEVELOPMENT
Does your child have difficulty:

a. learning new large motor skills?	NO YES

			Comments/Clarifications
b. hopping on one foot?	NO	YES	
c. jumping on two feet together?	NO	YES	
d. skipping?	NO	YES	
e. kicking a ball?	NO	YES	
f. catching a ball?	NO	YES	
g. learning how to use playground equipment?	NO	YES	
h. cutting or pasting?	NO	YES	
i. using small manipulative toys?	NO	YES	
j. learning to hold a pencil or crayon in a 3 point position?	NO	YES	
k. learning to write letters and numbers?	NO	YES	

Does your child have difficulty:

l. moving fast enough to keep up with peers when m. playing in a group?	NO	YES
n. keeping her/his balance or feeling confident enough to try activities that demand good balance?	NO	YES
o. having enough strength and endurance to keep up with same aged peers?	NO	YES
p. avoiding injury during active play?	NO	YES

7. SOCIAL ADJUSTMENT

Does your child:

a. find it hard to make friends among his/her peers?	NO	YES
b. prefer the company of adults or older children?	NO	YES
c. prefer playing with younger children?	NO	YES
d. play with age-appropriate toys?	NO	YES

8. SCHOOL PERFORMANCE

Does your child:

a. need to prop his/her head with a hand while reading or writing at a desk?	NO	YES
b. seem confused over which hand or foot is left or right?	NO	YES

c. make reversals of letters or numbers when writing?	NO	YES
d. read words in reverse?	NO	YES
e. find PE or sports to be difficult or frustrating?	NO	YES
f. have any learning problems? Please specify.	NO	YES

What are your greatest concerns for your child relative to his/her development and occupational therapy?

What are your child's strengths?

Please comment on your child's school behavior.

What are your child's favorite activities/stories?

What activities or situations bring out your child's most mature behavior?

Does your child behave differently at home than in other settings? Please describe.

What else would you like your OT to know about your child?

Has your child had any of the following examinations? If so, please give the approximate date and the examining person's name and address:

	Date	By Whom	Address
Most recent physical examination			
Neurology			
Psychiatry			
Psychology			
Education			
Speech and Hearing			
Other special examinations			

Additional information that would help us to better understand your child: