

# ABOUT MY CHILD • OCCUPATIONAL THERAPY

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Height: \_\_\_\_ ' \_\_\_\_ "      Weight: \_\_\_\_\_ lbs



What is the main reason you are seeking help for your child? \_\_\_\_\_  
\_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Emergency contact: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

Please list the names and relationships with whom the child is living: \_\_\_\_\_  
\_\_\_\_\_

Please list the names and relationships of any non-residential adults with whom the child is primarily involved: \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL STATUS

Food or medical allergies: \_\_\_\_\_  
\_\_\_\_\_

Illnesses currently being treated: \_\_\_\_\_  
\_\_\_\_\_

Medications presently taken: \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases (describe any complications): \_\_\_\_\_  
\_\_\_\_\_

Hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

Surgeries: \_\_\_\_\_

Head injuries (indicate level of unconsciousness): \_\_\_\_\_

Coma: \_\_\_\_\_

Convulsions: \_\_\_\_\_

Meningitis or encephalitis: \_\_\_\_\_

Immunization reactions: \_\_\_\_\_

Persistent high fevers (include highest temperature): \_\_\_\_\_

Eye problems: \_\_\_\_\_

Ear problems: \_\_\_\_\_

**PREGNANCY**

Mother's age at time of birth: \_\_\_\_\_

Complications:

Vomiting	Y	N
Excessive blood loss	Y	N
Threatened miscarriage	Y	N
Toxemia	Y	N

Infections \_\_\_\_\_

Surgeries \_\_\_\_\_

Other illnesses \_\_\_\_\_

Smoking during pregnancy?            Y        N        Number of cigarettes per day: \_\_\_\_\_

Alcohol during pregnancy?            Y        N        Describe: \_\_\_\_\_

Medications or other drugs during pregnancy: \_\_\_\_\_

**LABOR**

Duration of labor: \_\_\_\_\_            Circle one:    Spontaneous / Induced

Type of delivery:    Vertex (normal) / Breech / Caesarean

Birth weight: \_\_\_\_\_ lbs    \_\_\_\_\_ oz

Gestational age:    (AGA) Appropriate / Small (SGA)

Complications:

Cord around neck	Y	N	
Hemorrhage	Y	N	
Injury during delivery	_____		
Other (specify)	_____		

Respiration: Immediate / Delayed                      How long? \_\_\_\_\_

Cry: Immediate / Delayed                                      How long? \_\_\_\_\_

Mucus accumulation	Y	N	
Jaundice	Y	N	
Cyanosis (turned blue)	Y	N	
Incubator care	Y	N	How long? _____

Suck: Strong / Weak

Other complications: \_\_\_\_\_

**INFANCY—TODDLER PERIOD**

Were any of the following present to a significant degree during the first few years of life? If so, describe:

Did not enjoy cuddling \_\_\_\_\_

Not calmed by being held or stroked \_\_\_\_\_

Colic \_\_\_\_\_

Excessive restlessness (including diminished sleep) \_\_\_\_\_

Frequent head banging \_\_\_\_\_

Constantly into everything \_\_\_\_\_

Excessive number of accidents \_\_\_\_\_

**DEVELOPMENTAL MILESTONES**

Indicate the age at which your child reached the following developmental milestones. If you cannot recall, check off the approximate time:

	<b>Age</b>	<b>Early</b>	<b>Normal</b>	<b>Late</b>
Smiled	_____	_____	_____	_____
Sat without support	_____	_____	_____	_____
Crawled	_____	_____	_____	_____
Stood without support	_____	_____	_____	_____
Walked without assistance	_____	_____	_____	_____
Spoke first words	_____	_____	_____	_____
Said phrases	_____	_____	_____	_____
Said sentences	_____	_____	_____	_____

	<b>Age</b>	<b>Early</b>	<b>Normal</b>	<b>Late</b>
Bladder trained	_____	_____	_____	_____
Bowel trained	_____	_____	_____	_____
Rode tricycle	_____	_____	_____	_____
Rode bicycle	_____	_____	_____	_____
Buttoned clothes	_____	_____	_____	_____
Tied shoelaces	_____	_____	_____	_____
Named colors	_____	_____	_____	_____
Said alphabet in order	_____	_____	_____	_____
Began to read	_____	_____	_____	_____

**COORDINATION**

Rate your child on the following skills:

	<b>Strong</b>	<b>Average</b>	<b>Poor</b>
Walking	_____	_____	_____
Running	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Shoelace tying	_____	_____	_____
Buttoning	_____	_____	_____
Writing	_____	_____	_____
Athletic ability	_____	_____	_____

**COMPREHENSION & UNDERSTANDING**

Do you consider your child to understand directions and situations as well as other children of the same age?  
 Yes    No    Why or why not? \_\_\_\_\_

How would you rate your child's overall level of intelligence compared to others of the same age?  
 Below average    Average    Above average

**SCHOOL**

Rate your child in regards to academic achievement:

	<b>Strong</b>	<b>Average</b>	<b>Poor</b>
Preschool	_____	_____	_____
Kindergarten	_____	_____	_____
Current grade	_____	_____	_____

Has their classroom teacher made note of any of the following?

Does not sit still in seat	Yes	No
Frequently gets up and walks around the room	Yes	No
Shouts out; does not wait to be called upon	Yes	No
Will not wait for turn	Yes	No
Does not cooperate in group activities	Yes	No
Does not pay attention during storytelling	Yes	No
Does not respect the rights of others	Yes	No

Describe any other classroom behavioral issues: \_\_\_\_\_  
\_\_\_\_\_

**PEER RELATIONSHIPS**

Does your child seek friendships with peers? Yes No

Is your child sought by peers for friendship? Yes No

Your child plays primarily with others who are... Same age Younger Older

Briefly describe any issues your child may have with peers: \_\_\_\_\_  
\_\_\_\_\_

**HOME BEHAVIOR**

All children, to some degree, exhibit the kinds of behaviors listed below. Check off those that you believe your child exhibits to a higher degree when compared to peers of similar age:

- Hyperactivity (high activity level) \_\_\_\_\_
- Poor attention span \_\_\_\_\_
- Impulsivity (poor self-control) \_\_\_\_\_
- Easily frustrated \_\_\_\_\_
- Outbursts & screaming \_\_\_\_\_
- Sloppy table manners \_\_\_\_\_
- Interrupts frequently \_\_\_\_\_
- Does not listen when spoken to \_\_\_\_\_
- Hits other children \_\_\_\_\_
- Heedless to danger \_\_\_\_\_
- Excessive number of accidents \_\_\_\_\_
- Does not learn from mistakes \_\_\_\_\_
- Poor memory \_\_\_\_\_
- Poor relationships with siblings \_\_\_\_\_

**INTERESTS & ACCOMPLISHMENTS**

What are your child's main hobbies and interests? \_\_\_\_\_  
\_\_\_\_\_

What are a few of your child's greatest accomplishments? \_\_\_\_\_  
\_\_\_\_\_

What does your child like doing the least? \_\_\_\_\_  
\_\_\_\_\_

**MOTHER**

Occupation: \_\_\_\_\_ Highest grade completed: \_\_\_\_\_

Medical issues (specify): \_\_\_\_\_

Learning delays (specify): \_\_\_\_\_

Illnesses or diseases that run on mother's side of family: \_\_\_\_\_  
\_\_\_\_\_

**FATHER**

Occupation: \_\_\_\_\_ Highest grade completed: \_\_\_\_\_

Medical issues (specify): \_\_\_\_\_

Learning delays (specify): \_\_\_\_\_

Illnesses or diseases that run on father's side of family: \_\_\_\_\_  
\_\_\_\_\_

**SIBLINGS**

Name	Age	Medical, social or academic issues
_____	_____	_____
_____	_____	_____
_____	_____	_____

**LIST NAMES AND PHONE NUMBERS OF ANY OTHER PROFESSIONALS CONSULTED:**