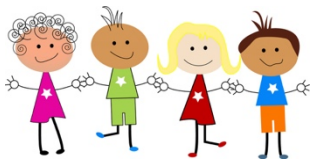
ABOUT MY CHILD • OCCUPATIONAL THERAPY

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: _____ Phone: (____) ____-____

Relationship: _____

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:

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

	Age	Early	Normal	Late
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:

	Strong	Average	Poor
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:

	Strong	Average	Poor
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: