CHILD HISTORY FORM

Date: ___________

Child's Name: ___________________ B.D: ___________ Age: _____ Sex: ____

Person Completing form: ___________________ Relationship to child: __________________
Telephone Number: _______________________ Referred by: ________________________

I. REASON FOR REFERRAL:

Occupations are the ordinary and familiar things that people do every day. Occupational Therapy helps children with performance of skills and participation in routines needed to be successful and independent with activities of daily living, education, play, leisure pursuits and social participation. Occupational therapy evaluation, treatment planning and intervention focus on helping children and families engage and succeed in meaningful life activities.

1. BACKGROUND

a. Reason for the occupational therapy evaluation____________________________________
____
____
____
____

b. What would you like to learn from this evaluation? ___________________________________
____
____
____
____

c. What are your child's strengths? What does s/he like to do? __________________________
____
____
____
____

d. What is your primary concern for your child at this time? What tasks are difficult for your child to perform?
____
____
____
____

e. What would you like to be easier for your child and/or your family? ___________________
____
____
____
____

II. OCCUPATIONAL PERFORMANCE

1. ACTIVITIES OF DAILY LIVING (ADL): Self Care

Describe how your child does the following activities: (Include any support needed to complete tasks)

Dressing and undressing self:

Buttoning, zipping, and snapping:

Tying shoes:

Bathing self:

Toileting:

Grooming and personal Hygiene:

Sleep and Self Regulation:

Mobility for Self care:

Eating and Feeding: (how mealtimes go; use of utensils; position/location of eating)

List foods your child currently eats:

History of Eating:

Was your child bottle-fed? __________ Type of formula? ______________
Was your child nursed? _________ How long? ___________________

Were there problems with breast or bottle-feeding? Please describe.

Were there difficulties with transitioning to solid foods? Please describe

2. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL): Daily activities oriented toward others and the environment

Describe your child's involvement in IADL such as chores, ability to get around, meal preparation, and safety.

3. EDUCATION/SCHOOL: Includes activities for being a student and participating in a learning environment.

Do you have any concerns regarding school? Please specify.

Do the child's teachers have any concerns? Please specify.

4. PLAY: Any spontaneous or organized activity that provides enjoyment, entertainment, amusement or diversion.

Describe your child's play including preferred activities and toys. What does your child do with the toys s/he enjoys?

5. WORK: Includes paid or volunteer activities (if applicable)

Describe any current concerns or future goals related to work and volunteer activities.

5. HEALTH MAINTENANCE AND LEISURE:

What things does your child like to do in his/her free time? How often?

Does your child participate in any organized activities? Please specify.

6. SOCIAL PARTICIPATION:

Does your child participate in any community activities? Please Describe

What types of activities does your family like to do together?

III. DEVELOPMENTAL AND MEDICAL HISTORY

Child's Regular Physician: ________________________________ Phone: _________________
Address: ____
Referring Physician: ____

1. PRE AND PERINATAL HISTORY

a. What was the length of pregnancy?

b. Were there any problems during pregnancy, labor, or delivery? Please describe.

____

____

____

c. Child's birth weight: __________________________ Apgar scores: ______________________

d. How long did your child stay in the hospital nursery? _________________________________

e. Were there any health problems during the first two weeks of life?

Please circle:	jaundice	breathing difficulties	oxygen	blueness
	tube fed	feeding difficulties	incubator or isolet	

Other (please describe):

2. GENERAL HISTORY

a. Has child been diagnosed as having any medical or educational conditions? If yes, describe. (Please provide records if possible)

b. Please give details on any hospitalizations, serious illnesses, or accidents. (Please provide records if possible)

c. Has child had any seizures, convulsions, or staring spells? If yes, describe.

d. Does child have allergies? If yes, describe and list any medications used.

e. Has your child seen any of the following specialists?

Specialty	Name of agency/specialist	Date	Results
Ophthalmologist Optometrist Vision test			
Audiologist Hearing test			
Occupational Therapist			
Speech Therapist			
Physical Therapist			
Psychologist Psychiatrist			
Orthopedist			
Cardiologist			

ENT			
Other			

f. Is child presently taking any medication? If yes, please list and state reason and frequency.

g. Circle the following that describe your child as an infant:

Fussy, irritable	Good, non-demanding	Quiet
Passive	Active	Liked being held
Resisted being held	Floppy when held	Tense when held
Good sleep patterns	Irregular sleep patterns	Overactive, rarely still

h. Give the approximate age in months at which the child did the following:

_____ Hold head erect   _____ Sit unsupported
_____ Roll   _____ Walk alone
_____ Crawl   _____ Eat solid foods/table foods

i. General impression of child's motor development:

Gross Motor: Slow_____   Normal_____   Advanced _____
Fine Motor   Slow_____   Normal_____   Advanced _____

j. Check which describes your child at present?

_____ Mostly quiet   _____ Overly active   _____ Tires easily
_____ Wets bed   _____ Restless   _____ Talks constantly
_____ Fights frequently   _____ Over reacts   _____ Frequent
_____ Difficulty learning new tasks   _____ Difficulty following directions
_____ Poor attention span/concentration   _____ Nervous habits/tics

k. Describe your child's overall behavior and emotional well being:

l. Does your child tantrum? ______ Does he bang his head or perform other self-abusive behaviors? ____ Please comment:

m. Describe discipline methods used at home.

n. How does your child learn best (moving, seeing, touching, hearing, talking)

o. Are there any speech, physical, or learning problems among family members? Please list relationship and problem.

p. Has your family experienced any recent crisis, major changes, or stress that may have influenced your child (financial problems, moves, job changes, divorce/separation, death, etc?)

q. Is there any other information that you feel is important for us to know about your child?

IV. IDENTIFICATION AND CARE COORDINATION

a. Family Information

Is the child adopted? ___________ Foster child? ________ If yes, since what age? ________
Parents are married ____ separated _____ divorced ____ widowed ____ single _____

Names, ages, and relationship of people living in the household:

NAME	AGE	RELATIONSHIP

b. School and Community Information

Child's School: __________________________________ Phone: _______________________
Teacher: ____Grade:__________________
School Schedule: ____

Has the child repeated any classes, skipped any classes, been in special education, received special education services? If yes, please describe.

We will send a copy of the Occupational Therapy evaluation report to you and your referring doctor. You may share the evaluation with other care providers as you would like. If you would like our department to share the evaluation, you will need to sign a release of information that the therapist or front office staff can provide.