

# Children's Therapy Center

## *Pediatric Occupational Therapy*

Helping children achieve their fullest potential.

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7881 Egleberry Street, Gilroy, CA 95020 • 408-842-1121

### **Client Information:**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Other Services Child is Receiving: \_\_\_\_\_

Service Coordinator/Referred By : \_\_\_\_\_

Reason For Referral: \_\_\_\_\_

### **Medical Information:**

Approximate date of last complete physical examination: \_\_\_\_\_

Approximate date of last eye examination: \_\_\_\_\_ By Whom: \_\_\_\_\_

Approximate date of last hearing examination: \_\_\_\_\_ By Whom: \_\_\_\_\_

What were the findings of these examinations? \_\_\_\_\_

Please list any medication your child is presently taking and the reason for the medication: \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_ If so please list them: \_\_\_\_\_

Has your child experienced frequent colds, ear infections, or other illnesses? Please explain: \_\_\_\_\_

Has your child had any serious illnesses, high fevers, convulsions, hospitalizations, or mild head traumas? Please explain: \_\_\_\_\_

**Pregnancy History:**

This is my: Natural born child\_\_\_\_\_ Adopted child\_\_\_\_\_ Foster child\_\_\_\_\_

Were there any complications experienced during pregnancy, labor, or delivery? Please explain: \_\_\_\_\_

\_\_\_\_\_

Was the mother exposed to, or did she experience any of the following, during pregnancy?

- \_\_\_\_\_ Rubella
- \_\_\_\_\_ Measles
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Toxemia
- \_\_\_\_\_ Other (explain): \_\_\_\_\_
- \_\_\_\_\_ Kidney Disease
- \_\_\_\_\_ Thyroid Disease
- \_\_\_\_\_ Heart Disease
- \_\_\_\_\_ Bleeding

**Child's Birth History:**

Was the child delivered full term or premature? How early? \_\_\_\_\_

Type of delivery: Vaginal \_\_\_\_\_ C-Section \_\_\_\_\_

If C-Section please state the reason:

\_\_\_\_\_

Did the baby have any difficulty breathing? \_\_\_\_\_

- If vaginal delivery, did baby present:
- Breech (feet first) \_\_\_\_\_
  - Transverse (Sideways) \_\_\_\_\_
  - Face presentation \_\_\_\_\_

Baby's birth weight: \_\_\_\_\_ Apgar score at: 1 minute: \_\_\_\_\_ 5 minutes \_\_\_\_\_

- 1) Did mother have any shocks or unusual stress during pregnancy? \_\_\_\_\_ Yes\_\_\_ No\_\_\_
- 2) Water break more than 24 hours before delivery? \_\_\_\_\_ Yes\_\_\_ No\_\_\_
- 3) Develop toxemia/high blood pressure during pregnancy? \_\_\_\_\_ Yes\_\_\_ No\_\_\_
- 4) Mothers age at delivery? \_\_\_\_\_

- Was or did the child:
- 1) Have cord wrapped around neck \_\_\_\_\_ Yes No
  - 2) Require forceps \_\_\_\_\_ Yes No
  - 3) Have birth injuries \_\_\_\_\_ Yes No
- Please explain: \_\_\_\_\_

- 4) Require a fetal monitor \_\_\_\_\_
- 5) Experience insufficient oxygen \_\_\_\_\_
- 6) Cry right away \_\_\_\_\_
- 7) Need intensive care hospitalization? \_\_\_\_\_
  - a. How long \_\_\_\_\_
  - b. Pre-maturity \_\_\_\_\_
  - c. Respiratory problems \_\_\_\_\_
  - d. Need respirator \_\_\_\_\_
  - e. Small for gestational age \_\_\_\_\_
  - f. Have a heart defect \_\_\_\_\_
  - g. Need transfusion \_\_\_\_\_
  - h. Jaundiced \_\_\_\_\_
  - i. Have congenital abnormalities \_\_\_\_\_
  - j. Have seizures \_\_\_\_\_
  - k. Have infection at birth \_\_\_\_\_
  - l. Have surgery as a newborn \_\_\_\_\_
  - m. Have feeding problems as a newborn \_\_\_\_\_

**Child's Developmental History:**

At what age did your child?

- |                      |                          |                      |
|----------------------|--------------------------|----------------------|
| _____ Roll           | _____ Sit                | _____ Dress self     |
| _____ Crawl          | _____ Pull to stand      | _____ Use silverware |
| _____ Stand Alone    | _____ Walk               | _____ Tie shoes      |
| _____ Say first word | _____ Say first sentence | _____ Feed self      |

How old was your child when s/he was toilet trained for day? \_\_\_\_\_ Night? \_\_\_\_\_

Which hand does your child prefer using, and at what age did that preference develop? \_\_\_\_\_

\_\_\_\_\_

Please list the areas of concern you have regarding your child's development: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Please note your child's strengths: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Please state your goals for your child. These may include things that you would like your child to learn to do better or feel more comfortable while doing-List goal and Priority.

GOAL

PRIORITY

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**Sensorimotor History**

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Date \_\_\_\_\_

Please think of the various stages of your child's development, consider behaviors which come to your mind as you are answering these questions. What do you think of as being different from other children you know? Were there times when his/her behavior became difficult to cope with in the family unit?

The following questions are posed to help compile a more complete picture of your child from infancy to their present developmental stage. Some of these questions may refer to children who are older than your own. Kindly cross out the verb tense that does not apply. Check the choice which does apply: Yes, No, Used to, or N/A (not old enough yet, or for other reasons nonapplicable.) Add narratives which would also be important on the back. Thank you for your cooperation.

**Taste and Smell**

Does child:	YES	NO	USED TO	N/A
1) Act as though all food tastes the same	___	___	_____	___
2) Explore with taste	___	___	_____	___
3) Chew on non food items	___	___	_____	___
4) Have any feeding problems	___	___	_____	___
5) Have trouble changing to textured foods	___	___	_____	___
6) Sensitive to any smells	___	___	_____	___
7) Taste or smell toys, clothes, etc, more than usual	___	___	_____	___
8) Take only tiny bites	___	___	_____	___
9) Take bites from the side of their mouth vs. the front of their mouth	___	___	_____	___

**Auditory**

Does child:	YES	NO	USED TO	N/A
1) Have a diagnosed hearing problem	___	___	_____	___
Comments: _____				
2) Have PE tubes in ears	___	___	_____	___
3) Have frequent ear infections	___	___	_____	___
4) Seem to be overly sensitive to sounds	___	___	_____	___
5) Respond negatively to unexpected sounds	___	___	_____	___

**Visual**

Does child:	YES	NO	USED TO	N/A
1) Have a diagnosed visual problem	___	___	_____	___
Comments: _____				
2) Seem very sensitive to light	___	___	_____	___
3) Have trouble following with eyes	___	___	_____	___
4) Avoid eye contact	___	___	_____	___
5) Become distracted by visual stimuli	___	___	_____	___
6) Dislike having eyes covered	___	___	_____	___
7) Close eyes for short periods when requested	___	___	_____	___
8) Make reversals when coping or reading	___	___	_____	___
9) Like playing in the dark	___	___	_____	___
10) Have trouble discriminating shapes or colors	___	___	_____	___
11) Squint often	___	___	_____	___
12) Able to look at something far away	___	___	_____	___
13) Able to look at something close	___	___	_____	___

**Tactile**

Does child:	YES	NO	USED TO	N/A
1) Like to be touched	___	___	_____	___
2) Dislike being held or cuddled	___	___	_____	___
3) Prefer to touch rather than be touched	___	___	_____	___
4) Seem excessively ticklish	___	___	_____	___
5) Seem easily irritated or enraged when touched by siblings or playmates	___	___	_____	___
6) Have a strong need to touch objects or people	___	___	_____	___
7) Seem to pick fights	___	___	_____	___
8) Pinch, bite or otherwise hurt self or others	___	___	_____	___
9) Like to touch animals	___	___	_____	___
10) Dislike the feeling of certain clothing	___	___	_____	___
11) Over or under dress for the temperature	___	___	_____	___
12) Overheat easily	___	___	_____	___
13) Seem overly sensitive to food/water temperature	___	___	_____	___
14) Seem overly sensitive to rough food textures	___	___	_____	___
15) Prefer baths over showers if the choice is available	___	___	_____	___
16) Like to play in water, mud, sand, clay, etc.	___	___	_____	___
17) Seem to lack normal awareness of being touched	___	___	_____	___
18) Often seem unaware of cuts or bruises until brought to his/her attention	___	___	_____	___
19) Avoid using hands	___	___	_____	___
20) Examine objects or clothes with hands	___	___	_____	___
21) Excessively mouths clothes or objects	___	___	_____	___

**Vestibular**

Does child:	YES	NO	USED TO	N/A
1) Arch back when held or moved	___	___	_____	___
2) Enjoy being rocked	___	___	_____	___
3) Like being tossed into the air	___	___	_____	___
4) Like to swing	___	___	_____	___
5) Spin or whirl more than other children	___	___	_____	___
6) Get carsick easily	___	___	_____	___
7) Get nauseous and/or vomit during movement experiences	___	___	_____	___
8) Rock while sitting	___	___	_____	___
9) Jump a lot	___	___	_____	___
10) Have fear in space (stairs or heights)	___	___	_____	___
11) Lose balance easily	___	___	_____	___
12) Misunderstand words used in relation to movement or position	___	___	_____	___
13) Dislike having their feet dangle	___	___	_____	___
14) Frequently have sweaty palms	___	___	_____	___

**Proprioception**

Does child:	YES	NO	USED TO	N/A
1) Overstuff mouth with food when eating	___	___	_____	___
2) Frequently bump or push others	___	___	_____	___
3) Bang head on purpose	___	___	_____	___
4) Walk on toes instead of flat feet	___	___	_____	___
5) Like to be squeezed or hugged tightly	___	___	_____	___
6) Throw themselves onto the floor a lot	___	___	_____	___

**Muscle Tone**

Does child:	YES	NO	USED TO	N/A
1) Feel heavier than s/he looks	___	___	_____	___
2) Have good endurance	___	___	_____	___
3) Have any diagnosed muscle problems	___	___	_____	___
4) Have flat feet	___	___	_____	___
5) Slump when sitting	___	___	_____	___
6) Get tired easily	___	___	_____	___
7) Seem generally weak	___	___	_____	___
8) Keep mouth open	___	___	_____	___
9) Prefer to lie on back rather than stomach	___	___	_____	___

**Coordination**

Did/ does child:	YES	NO	USED TO	N/A
1) Sit, stand or walk late	___	___	_____	___
2) Sit, stand or walk early	___	___	_____	___
3) Was the creeping/crawling phase unusually long	___	___	_____	___
4) Was the crawling phase basically omitted	___	___	_____	___
5) Are movements slow, prodding or deliberate	___	___	_____	___
6) Play with toys appropriately for age	___	___	_____	___
7) Creep on tummy or bottom	___	___	_____	___
8) Play with toys in clumsy, awkward manner	___	___	_____	___
9) Trip or fall a lot	___	___	_____	___
10) Seem clumsy or awkward	___	___	_____	___
11) Bump into things a lot	___	___	_____	___
12) Handle small things easily	___	___	_____	___
13) Eat neatly for age	___	___	_____	___
14) Have rigid movements	___	___	_____	___

**Behavior/Temperament**

Does or is child:	YES	NO	USED TO	N/A
1) Quiet/calm/relaxed/patient	___	___	_____	___
2) Active, outgoing, enthusiastic	___	___	_____	___
3) Intense, easily frustrated, anxious	___	___	_____	___
4) Explosive	___	___	_____	___
5) Seem hyperactive, always in perpetual motion	___	___	_____	___
6) In the same mood all day as when he/she wakes up	___	___	_____	___
7) An early riser, immediately on the go	___	___	_____	___
8) Cry excessively in infancy	___	___	_____	___
9) Clingy	___	___	_____	___
10) Predictable	___	___	_____	___
11) Rigid, set in ways	___	___	_____	___
12) Adaptable, flexible	___	___	_____	___
13) Regular sleep patterns	___	___	_____	___
14) Difficult to get to sleep	___	___	_____	___
15) Wakes frequently	___	___	_____	___
16) Screams when wakes during the night	___	___	_____	___
17) Able to play alone for a reasonable length of time	___	___	_____	___
18) Destructive with toys	___	___	_____	___
19) Short attention span	___	___	_____	___
20) Distractible	___	___	_____	___
21) Demonstrate self-stimulating behaviors	___	___	_____	___
22) Have frequent tantrums	___	___	_____	___
23) Display extreme mood changes	___	___	_____	___
24) Unable to adjust to routine changes	___	___	_____	___
25) Aggressive, acting out behavior	___	___	_____	___
26) Seem discouraged or depressed	___	___	_____	___