Children's Therapy Center

Pediatric Occupational Therapy

Helping children achieve their fullest potential.

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

Client Information:

Client Name:____________________________ Date of Birth: ____________Age:______

Name of school:__________________________Grade in school: ____________________

Special school program:____

Other Services Child is Receiving:____

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 _____Kidney Disease

_____Measles _____Thyroid Disease

_____Diabetes _____Heart Disease

_____Toxemia _____Bleeding

_____Other (explain):____

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___
   Explain:________________________________
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 Yes No

1) Have cord wrapped around neck ___ ___
2) Require forceps ___ ___
3) Have birth injuries ___ ___
   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 they were toilet trained for day? _______Night? ________

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

____

Child's school history

According to school personnel, your child's IQ is:____Below average _____Average ____Above average

Do your child's grades appear consistent with his/her abilities? ______________________

Have school personnel reported difficulties for your child in the following areas?

Explain:

Behavior:____

Sports/playground:____

Concentration:____

Social interactions:____

Certain academic subjects:____

Has your child:

Failed a subject:____

Been tutored:____

Made satisfactory grades:____

Been in special education classes:____

Does your child: _____ Like school _____ Hate school _____Indifferent

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
____
____
____
____
____
____

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	___	___	______	___

	YES	NO	USED TO	N/A
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	___	___	______	___

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	___	___	______	___

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				

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 other 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 has sweaty palms				

Proprioception

Does child:				
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 he/she looks				
2) Have good endurance				
3) Have any diagnosed muscle problems				
4) Have flat feet				
5) Slump when sitting				

	YES	NO	USED TO	N/A
6) Get tired easily	___	___	_______	___
7) Seem generally weak	___	___	_______	___
8) Keep mouth open	___	___	_______	___
9) Prefer to lie on back rather than stomach	___	___	_______	___

<u>Learning Styles</u>

Does child:	YES	NO	USED TO	N/A
1) Learn from mistakes	___	___	_______	___
2) Recognize own errors	___	___	_______	___
3) Acquire materials needed for a task	___	___	_______	___
4) Able to set up a work space	___	___	_______	___
5) Maintain a work space	___	___	_______	___
6) Able to work independently	___	___	_______	___
7) Generalize known skills to acquire new skills	___	___	_______	___
8) Demonstrate age appropriate memory	___	___	_______	___
9) Ask for help appropriately	___	___	_______	___
10) Plan ahead	___	___	_______	___
11) Create new ideas and ways of doing things	___	___	_______	___
12) Age appropriate content in written language	___	___	_______	___
13) Gets work done on time	___	___	_______	___
14) Average reading level	___	___	_______	___
15) Average math level	___	___	_______	___

<u>Coordination</u>

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	___	___	_______	___

<u>Behavior/Temperament</u>

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) Seems to be a loner ___ ___ ______ ___
27) Expresses feelings of low self esteem ___ ___ ______ ___
28) Expresses feelings of failure and frustration ___ ___ ______ ___
29) Seem discouraged or depressed ___ ___ ______ ___
30) Prefer the company of adults or older children ___ ___ ______ ___
31) Prefer playing with children 1-2 years younger ___ ___ ______ ___