PATIENT INFORMATION AND BACKGROUND HISTORY

FAMILY INFORMATION:

Patient's Full Name**:** _____

Date of Birth: _____ Age:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell_____

Parent/Guardian's Name: _____

Telephone: _____ Cell:_____

E-Mail Address: _____

REFERRING INFORMATION:

Who referred this child for an evaluation: _____

Who is your child's present Physician: _____

Other professionals working with your child:_____

Reason for Referral: _____

_____

MEDICAL HISTORY:

Patient Diagnosis: _____

Born prematurely: **YES** · **NO** ·

How many weeks gestation: _____ Birth Weight_____

Any complications during pregnancy: **YES** · **NO** · If yes, please explain:

_____

_____

_____

Any complications in early infancy: **YES** · **NO** · If yes, please specify: _____

_____

_____

_____

Any complications with feeding in early infancy: **YES** · **NO** · If yes, please specify: _____

_____

_____

Does your child have now or in the past had (significant health problems, surgery, hospitalizations, respiratory or lung problems, cardiac problems, seizures, allergies, ear infections, etc):

YES · **NO** · If yes, please specify:_____

_____

_____

_____

Is your child currently on medications: **YES** · **NO** · (If yes, please give a list and state reason):

_____

Has your child's hearing been evaluated by an Audiologist: **YES** · **NO** ·

By whom: _____Date:_____

Has your child's vision been evaluated by a Pediatric Ophthalmologist or Developmental Optometrist:

YES · **NO** · **By whom: _____**
Date:_____

DEVELOPMENTAL HISTORY

Approximate age child achieved the following milestones:

Attained head control: _____ Finger Feeding:_____

Rolled over: _____ Eating with spoon:_____

Crawled: _____ Spoke Sentences: _____

Walked: _____ Dressing: _____

Babbled: _____ Toilet Trained: _____

1st words: _____

Hand Preference: Right · **Left** · **Both** ·

Does your child sleep through the night? **YES** · **NO** ·

Does your child have difficulty learning new motor skills? **YES** · **NO** ·

Current Therapy/Services: (PT, OT, Speech, ABA/Educational, Counseling, Etc.)

Please list names of providers:

_____

_____

_____

_____

Current School Placement: _____Grade: _____

Does your child have an IEP (if so, what services are they receiving): _____

_____

_____

What areas do you feel need to be addressed in occupational therapy: _____

_____

_____

_____

What achievements/goals would you like to see your child attain? _____

_____

_____

_____

Any additional comments/concerns: _____

_____

_____

_____

Your child's interests and favorite toys/activities: _____