CENTER OF DEVELOPMENTAL PEDIATRICS

AN OCCUPATIONAL THERAPY CLINIC

PATIENT BACKGROUND INFORMATION

Patient Name: _____ Today's Date: _____
Sex: M / F Birthdate: _____
Address: _____
Phone: _____ Email: _____

Father/Guardian's Name: _____
Address: _____
Phone: Home: _____
Phone: Work: _____ Cell: _____
Occupation: _____
Employer: _____

Mother/Guardian's Name: _____
Address: _____
Phone: Home: _____
Phone: Work: _____ Cell: _____
Occupation: _____
Employer: _____

Physician's Name: _____
Address: _____
Phone: _____

Emergency Contacts
Name: _____ Name: _____
Phone: _____ Phone: _____
Relationship: _____ Relationship: _____

Education
School Name: _____
Address: _____ Phone: _____
Grade: _____ Teacher: _____ Class Type: _____

Siblings or others living in patient's home (include age and relationship to patient):

Name	Age	Relationship

Referred by: _____
Primary Concern: _____

Birth History:

☐ Vaginal Delivery ☐ Cesarean Section

☐ Premature Gestational Age: _____ ☐ NICU Admission Duration: _____

Birth Weight: _____ lbs. _____ oz. Length _____ Apgar score: _____

Oxygen given at birth? YES / NO

Complications (if any, please indicate): _____

_____

_____

Medical History (Diagnoses/Surgical Procedures/Doctor Appointments):

_____

_____

_____

_____

_____

Please check all that apply:

- ☐ Allergies: _____
- ☐ Special Diet: _____
- ☐ Seizures: Frequency: _____ Type: _____ Date of last one: _____
- ☐ Asthma
- ☐ Chicken Pox
- ☐ Ear Infections: How many? _____
- ☐ Tubes in ears: Procedure Date: _____ Are they still present? YES / NO

Has patient been evaluated/treated by a Neurologist and/or Diagnostician? YES / NO

If yes, please fill in the following information:

Name: _____ Facility name: _____

Address: _____

Phone: _____

Evaluation Date: _____

Results of evaluation: _____

Has patient been evaluated/treated by a Psychologist and/or Psychiatrist? YES / NO

If yes, please fill in the following information:

Name: _____ Facility name: _____

Address: _____

Phone: _____

Evaluation Date: _____

Results of evaluation: _____

Has patient had IQ testing? YES / NO

If so, please fill in the following information:

Evaluation used: _____

Results: _____

Has patient been evaluated/treated by a Speech, Occupational and/or Physical Therapist? YES / NO

If yes, please fill in the following information:

Facility name: _____

Address: _____

Therapist Name: _____ Speech / Occupational / Physical *(circle one)*

Diagnosis: _____

Dates of Service: _____

Vision: Date last checked: _____ Results: _____

Hearing: Date last checked: _____ Results: _____

Immunizations current: YES / NO If no, Action taken: _____

Medications:

Name	Dosage	Purpose	When was it prescribed?	Prescribing Physician

Family Medical History

Please list family member(s), relationship to patient and diagnosed disorder:

Emotional: _____

Mental: _____

Learning: _____

Neurological Difficulty/Disorder: _____

Other:

_____

Developmental History

Please state approximate age at which patient the following milestones occurred:

Smile: _____ Toilet train: _____

Roll over: _____ Dress him/herself: _____

Hold bottle: _____ Fasten Clothes: _____

Sit unsupported: _____ Tie shoes: _____

Crawl: _____ Speak words: _____

Walk: _____ Use full sentences: _____

Ride bike: (with training wheels) _____ (without training wheels) _____

Hand Dominance: RIGHT / LEFT Established at what age? _____

Feeding History

☐ Breastfed ☐ Bottle-fed Age Weaned: _____

Any early difficulties with gagging, choking, chewing difficulties, or swallowing? ☐ YES ☐ NO

If yes, please explain:

_____

Any present difficulties? ☐ YES ☐ NO
If yes, please explain:

_____

At what age were solid foods introduced? _____

Does the child have preference or avoidance of any particular food types, textures, temperature, or tastes? ☐ YES ☐ NO
If yes, please explain:

_____

Any difficulties self-feeding like other children of the same age? ☐ YES ☐ NO

Does your child have difficulty with the following?
☐ spoon ☐fork ☐ knife ☐straw cup ☐ open cup

Educational History
Please list all previous and current attended schools and dates attended:

_____
_____
_____
_____
_____

Please check any area(s) of difficulty patient has in school/academics:

☐ Conduct/Behavior	☐ Math	☐ Peer Socialization
☐ Fine Motor	☐ Reading	☐ Organizing work
☐ Gross Motor	☐ Spelling	☐ Staying focused on task
☐ Homework	☐ Handwriting	☐ Unstructured time
☐ Playground	☐ P.E.	

Other: _____

How is your child coping at school? _____

Please check any which best describe the patient:

☐ Outgoing	☐ Happy	☐ Aggressive
☐ Fearless	☐ Quiet	☐ Anxious
☐ Usually moving	☐ Cheerful	☐ Frustrated
☐ Careless	☐ Shy	☐ Impulsive
☐ Talkative	☐ Quiet	☐ Bully
☐ Distractible	☐ Hard to discipline	☐ Accident prone

Other: _____

Is there are a certain time of day or a certain part of your child's daily routine that is difficult for your child?

_____
_____

Is there any other information you feel would be helpful as we evaluate your child?

_____
_____
_____
_____
_____

What do you hope to learn from this evaluation?

_____
_____
_____
_____
_____

SENSORY QUESTIONAIRE

Motor Planning – Praxis

- Is your child impulsive when asked to perform motor tasks? ☐ YES ☐ NO
- Is he/she accident prone? ☐ YES ☐ NO
- Does he/she avoid motor activities and prefer sedentary ones? ☐ YES ☐ NO
- Is your child generally disorganized in his/her approach to tasks? ☐ YES ☐ NO
- Does he/she have difficulty with any of the following? *Please explain if necessary.*
  - Dressing him/herself_____
  - Opening and closing buttons and zippers_____
  - Tying shoelaces_____
  - Drawing/writing_____

Vestibular Processing and Bilateral Integration

- Does your child have trouble walking up and down stairs? ☐ YES ☐ NO
- Does he/she seem uncomfortable sitting in a chair or maintaining an adequate sitting posture? ☐ YES ☐ NO
- Was he/she slow to learn to jump or hop on one foot? ☐ YES ☐ NO
- Does he/she have difficulty with balance? ☐ YES ☐ NO
- How does he/she respond to fast moving equipment? ☐ YES ☐ NO
- Does he/she get carsick? ☐ YES ☐ NO
- Is he/she fearful of playground equipment? ☐ YES ☐ NO
- Does he/she position his/her paper to the extreme right when drawing or writing? ☐ YES ☐ NO
- Does he/she have trouble catching a ball with both hands? ☐ YES ☐ NO

Tactile (Touch)

- How does your child respond to having close physical contact with other children?
  _____
- Does he/she become agitated when other children are nearby? ☐ YES ☐ NO
- How does he/she feel about putting his/her hands into paint, sand, glue, etc.?
  _____

- Does he/she dislike being touched? Particularly as a baby, did he/she dislike being cuddled? ☐ YES ☐ NO

- Is he/she hypersensitive to different food or clothing textures (example: will only eat crunchy foods or dislikes jeans, tags, socks, shoes)? ☐ YES ☐ NO

- How does your child feel about hair washing, combing, cutting, etc.?
  _____

- Is he/she unaware of cuts and bruises? ☐ YES ☐ NO

- Does he/she complain about minor physical injuries more than other children? ☐ YES ☐ NO

Socialization/Play Behaviors/Interests

- Is the child able to separate from primary caregiver? ☐ YES ☐ NO
-
- How does the child get along with caregivers? _____

- What are the child's strengths? _____
  _____

- How does the child get along with other children? _____
  _____

- How does the child respond to new situations, people and places? _____
  _____

- How does the child's reaction to discipline? _____

- Does the child have Tantrums/Aggression? ☐ YES ☐ NO
  If yes, please explain.
  _____

- Does your child demonstrate any repetitive or unusual behaviors ☐ YES ☐ NO
  If yes, please explain.
  _____

- Does your child enjoy playing with other children? ☐ YES ☐ NO

- Does your child take turns and share toys with others? ☐ YES ☐ NO

- Describe child's play with toys, peers, and adults: _____
  _____

- What are the child's favorite toys and activities? _____