



Client Medical History

Date:	
Child's Name:	Date of Birth:
Parents/Guardian:	Home phone:
Address:	Email:
	Cell phone:
Father's Employer:	Work phone:
Mother's Employer:	Work Phone:
Insurance Company:	Insured's Name:
Policy Number:	Group Number:
Who referred your child to OT?	Insured's SS#:
Client's SS#:	Primary Physician:

Birth history:

Please describe your child's birth history. List any complications during pregnancy, birth or infancy?

Was prenatal care initiated? If yes, at what month?

How long was the pregnancy?

How long was the labor?

How long was the child hospitalized after birth?

Was an epidural used?

Is your child adopted?

Does your child know that he or she was adopted?

At what age was he or she adopted?

Was your child breastfed or bottle-fed?

As an infant, did your child experience:

Jaundice	Seizures
Cyanosis	Plagiocephaly
Torticollis	Anoxia (umbilical cord complications)
Pneumonia	Other

Parent History:

Check what may apply

<u>Maternal History</u>	<u>Paternal History</u>
ADD/ADHD	ADD/ADHD
Learning Disability	Learning Disability
Autism/Aspergers	Autism/Aspergers
Anger Management	Anger Management
Depression	Depression

Child's Developmental motor history: State age in months or years

Sat up alone	
Pulled self to standing	Finger fed
Crawled	Used utensils to feed self
Walked	Undressed self
Rode tricycle	Dressed self
Rode bicycle	Buttoned/Zippered
Reached for Toy	Talking in 2-3 word combinations

Does your child have a history of ear infections?

Has your child ever needed tubes?

Is your child hearing impaired?

Is your child vision impaired?

Does your child have any allergies? If yes, are they being medically managed? Do you think your child displays behaviors related to allergies?

Does your child currently take any medications? If yes, please list the dosage and the condition that is being treated?

Have there been any life changing events in your child's history such as loss of a loved one, divorce or separation or move?

Please list the professionals that your child has seen with contact information:

Name and Phone Number:

Psychologist	
Neurologist	
Occupational Therapist	
Physical Therapist	
Speech Therapist	
Allergy Specialist	
Sleep Specialist	
Psychiatrist	
Social Worker	
Educational Specialist	
Developmental Optometrist or Ophthalmologist	
Other	

Please describe techniques previously used in treatment that have been successful and as well as what has not been successful?

School History: Please list your child's school history and describe current classroom setting:

Name of School and Teacher:	Grade:

Behavioral/Emotional History:

Compliant	
Displays affection towards others	
Displays aggression towards self	
Displays aggression towards others	
Irritable	
Cries easily	
Seems happy	
Seems immature when compared to peers	
Displays rapid mood swings	
Seems independent	
Seems dependent	
Baby talks	
Seems to need a lot of comfort and nurturing	
Seems impulsive	
Difficult to discipline	
Blames others for own mistakes	
Seems remorseful	

Communication:

Initiates eye contact when greeting someone	
Initiates eye contact when requesting information	
Sustains eye contact	
Takes turns	
Interacts with peers	
Interacts with adults	
Participates in conversations	
Responds to verbal information in a timely manner (there is little lag in response time)	
If your child is non verbal, please describe the vocalizations or how your child communicates (signing, gestures)	

Self care:

Please describe the level of assistance that you provide with the following self care activities with 1 being the “least” (the child is independent) to 5 being the “most”:

Tooth brushing:

Hair washing:

Bathing:

Dressing:

Haircuts:

Sits for meals:

Keeps track of own belongings:

Organizes homework:

Transitions easily:

Toileting skills:

Arousal/Attention/Self-Regulation: Yes or No?

Is an early morning riser	
Awakens during the night	
Has difficulty falling asleep	
Is irritable upon waking	
Wets bed	
Attends to toys	
Attends to school	
Attends to new environments	
Able to sustain attention	
Independently explores	
Are there certain times of the day where your child seems happier or more irritable?	

Balance/Body Awareness Praxis: Yes or No?

Initiates new activities	
Understands how to play with new toys	
Plays with the same toy in a variety of ways	
Able to perform sequential tasks	
Jumps	
Plays on playground equipment (slides, jungle gym, monkey bars, etc.)	
Swings	
Enjoys rough house play	

Takes risk	
Seems aware of safety concerns	
Can your child descend and climb stairs alternating steps?	
Balance on a balance beam?	
Is your child afraid of heights or movement?	
Does your child get motion sickness in the car?	

Parental Concerns:

What do you see as your child's strengths?

What are your concerns about your child?

What do you hope your child will gain by being seen by Crossway Occupational Therapy?

Signature: