Child Case History Form (Occupational Therapy)

Welcome to Auburn TLC! In order to help us achieve our mission of providing the highest quality treatment for your child, please fill out this form as accurately as possible. We look forward to working with you and your child.

Today's Date: _____

Child's Name: _____Nickname: _____

Prenatal and Birth History

Mom's age at birth _____ Dad's age at birth _____

Length of Pregnancy _____ Child's weight at birth _____

Type of Delivery: ☐ Vaginal ☐ Caesarian ☐ Breech

Any illnesses or accidents experienced during pregnancy? ☐ Yes ☐ No

If yes, please provide details, including any medications used. _____

_____

Was your child's delivery normal? ☐ Yes ☐ No If no, please provide details _____

_____

Did your child experience any health problems during or after birth? (health, swallowing, sucking, feeding, sleeping) ☐ Yes ☐ No

If yes, please provide details: _____

_____

Medical History

Has your child ever had surgery? ☐ Yes ☐ No When? _____

If yes, please explain: _____

_____

Has your child ever been hospitalized for a serious illness? ☐ Yes ☐ No

If yes, indicate when and explain:

_____

Has your child ever experienced any of the following? Check all that apply and please indicate age of occurrence:

ILLNESS	YES	AGE	ILLNESS	YES	AGE
Adenoidectomy			Headaches		
Allergies			Head injury		
Asthma			Heart problems		
Blood Disease			High fevers		
Chickenpox			Influenza		
Chronic Colds			Measles/Mumps		
Croup/whooping cough			Neuromuscular Disorders		
Dental problems			Rheumatic Fever		
Ear Infections			Pneumonia		
Ear tubes inserted for ear infections			Other _____ _____		
Encephalitis/Meningitis					

Speech and Language Development

At what age did your child speak his or her first word? _____

Did it ever seem like your child started losing words? ☐ Yes ☐ No

How does your child primarily communicate? ☐ Pointing ☐ Gestures ☐ Grunting ☐ Crying

☐ 2 -3 Word Phrases ☐ 2-4 Word Sentences ☐ Sentences longer than 4 words

When your child uses words, what percentage of his/her speech is understood? _____

Does your child understand the following? ☐ His/Her Name ☐ Names of Body Parts ☐ Object Labels
☐ Names of Family Members ☐ Simple Directions ☐ Who/What/When/Why/How Questions

Gross Motor Development

Did your child experience any delays in achieving his or her milestones? ☐ Yes ☐ No

If yes, please indicate below:

Milestone	Age at which achieved	Still an area of concern
Holding head up while lying on stomach		
Rolling over		
Sitting up unassisted		
Crawling		
Pulling to stand		
Cruise along furniture		
Standing unassisted		
Walking unassisted		

Fine Motor Skills Development

Did your child experience any delays in achieving his or her milestones? ☐ Yes ☐ No

If yes, please indicate below:

Milestone	Age at which achieved	Still an area of concern
Reaches and grasps objects		
Transfers objects from one hand to the other		
Grasping objects with index finger and thumb		
Feeds self with fingers and/or utensils		
Stacks blocks		
Copies drawn lines and cuts with scissors		
Counts to 5 using fingers		
Uses knife for cutting		
Correctly holds a pencil/crayon		
Writes own name		
Completes simple puzzles		

Area(s) of Concern

What are your concerns about your child's development? _____

_____

When did you notice these concerns? _____

Has your child previously received services for these concerns? ☐ Yes ☐ No

If yes, when and where: _____

_____

Education History

Does the child attend day care or school? ☐ Yes ☐ No

Name of Day Care or School: _____

Grade (if attending school): _____ Teacher's Name_____

Does your child have an Individualized Education Plan (IEP)? ☐ Yes ☐ No

If yes, please provide a copy of the IEP.

Does the child have any siblings? ☐ Yes ☐ No (If yes, please list below)

Name	Age	Sex	History of speech, language, hearing or medical problems?

Is English the primary language spoken in the home? ☐ Yes ☐ No

Other language(s) spoken in the home? _____

Please list any diagnoses your child has:

_____

_____

Is your child currently taking any medications? ☐ Yes ☐ No (If yes, please indicate below):

Medication	How often?	For what purpose?

Please list any allergies your child has, especially food allergies:

_____

Behavior

Please check 'YES' for all that apply to your child:

BEHAVIOR	YES	Describe
Eating problems or picky eater		
Sleeping problems		
Doesn't play appropriately with toys		
Short attention span		
Overactive		
Underactive		
Cries a lot		
Doesn't follow directions		
Easily upset		

Self-Help Skills

Please check the box next to the skills your child is able to complete independently.

☐ Puts on shirt ☐ Buttons pants/shirt ☐ Zips pants/jacket ☐ Drinks from a sippy cup

☐ Ties shoes ☐ Washes hair ☐ Takes shirt off ☐ Puts pants on

☐ Takes pants off ☐ Puts socks/shoes on ☐ Takes socks/shoes off ☐ Bathes body

☐ Drinks from open cup ☐ Drinks from straw ☐ Feeds self with spoon ☐ Feeds self with fork

Bladder trained during day: YES NO Age: _____ Bladder trained at night: YES NO Age: _____

Bowel trained during day: YES NO Age: _____ Bowel trained at night: YES NO Age:_____

Please provide additional comments pertaining to the completion of these skills: _____

_____

_____

Social/Emotional Development

Please check the boxes that describe your child.

☐ Mostly quiet ☐ Talks constantly ☐ Fights frequently ☐ Overly active ☐ Impulsive

☐ Tires easily ☐ Demonstrates destructive behavior ☐ Falls often ☐ Resistant to change in routine

☐ Prefers to play alone ☐ Becomes easily frustrated ☐ Rocks self frequently ☐ Likes to be held

☐ Clumsy/uncoordinated ☐ Follows simple directions ☐ Demonstrates poor eye contact

☐ Exhibits frequent temper tantrums ☐ Displays unusual fears ☐ Displays nervous habits or tics

☐ Displays poor attention span

Please provide additional comments pertaining to concerns with social/emotional development: _____

_____

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