PlayWorks Occupational Therapy, PLLC

OCCUPATIONAL THERAPY -- MEDICAL HISTORY—PRESCHOOL / School Age

Child's Name:_____ Date of Birth: _____ Age: _____

Completed by: _____Relationship to Pt: _____Today's Date:_____

Reason for referral: _____

Referring doctor: _____ Last visit: _____

1. **Birth History:** Full term? Y / N Pregnancy complications? Y / N Pregnancy length: _____ weeks
   Type delivery_____Length of time infant in hospital after birth: _____

   Please explain any pregnancy or birth complications: _____
   _____
   _____

2. **Hospitalizations since birth** (note age & reason):

_____

_____

2. **Major Illnesses / Injuries or surgeries**: _____

   _____

4. Regular prescription **medications**: Y / N if yes, please list: _____

_____

5. **Allergies**/ medications: _____

_____

6. Previous **accidents, fractures**, etc.? _____

_____

7. **Seizures**: _____

8. **Hearing** checked: Y / N When: _____ Diagnosed hearing loss? _____

9. **Vision** evaluated with optometrist/ophthalmologist: Y / N last exam: _____
   Name of the doctor: _____

10. Any other medical conditions or delays that we should be aware of?

_____

_____

11. Any diagnosed **speech** delay? _____
    Treatment: _____

DEVELOPMENTAL HISTORY

1. **At what age did your child**: (please specify ages as near as possible or note N/A for not achieved yet)	Age
Roll over both ways	
Sit alone	
Belly crawl	
Crawl on hands/knees	
Walk without assistance	
Speak his/her first word (what was it?)	
Speak his/her first phrase/sentence (what was it?)	

2. Describe infancy:	Always	Frequently	Occasionally	Seldom	Never	N/A
Cried a lot, fussy, irritable						
Was alert						
Was active						
Like being held						
Resisted being held						
Was floppy when held						
Was tense when held						
Had irregular sleep patterns						
Sucking/swallowing/chewing difficulties						

3.Describe your child presently	Always	Frequently	Occasionally	Seldom	Never	N/A
Is mostly quiet						
Is overly active						
Tires easily						
Talks constantly						
Impulsive						
Stubborn						
Resistant to changes in routines, people, environment						
Overreacts to disappointments						
Fights frequently with siblings, peers						
Is usually happy, cooperative						
Exhibits frequent temper tantrums						
Is clumsy, accident prone						
Has difficulty separating from primary caretaker						
Has nervous habits or tics						
Falls often						
Wets bed						
Has poor attention span						
Is frustrated easily						
Has unusual fears						
Rocks self frequently						
Has difficulty learning new tasks (i.e. writing, throwing, a ball, riding a bike, work tasks, chores, etc)						

Comments: _____

_____

4. Activities at the present: (as apply) School -- _____ Class/Grade -- _____
Favorite play activities:

_____

_____

5. Why are you seeking an OT assessment at this time? Please note your concerns, unmet goals for your child:

_____

_____

_____