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Patient History Form

Name: ______________________________

Date of Birth: ____________________ **Age:** ________ **Sex:** ☐ Male ☐ Female

Address: ______________________________

City: ____________________ **State:** __________ **Zip** __________

Telephone: ______________________________

Person Completing This Form: ______________________________

Relationship to Client: ______________________________

Parent's Name: ____________________ **Age:** ________

Address: ______________________________

City: ____________________ **State:** __________ **Zip:** __________

Parent's Name: ____________________ **Age:** ________

Address: ______________________________

City: ____________________ **State:** __________ **Zip:** __________

Parent's Occupation: ______________________________

Who lives in the home with the child? ______________________________

Has the child or any member of the family been tested positive for COVID-19? ☐ Yes ☐ No

List all children in the family from oldest to youngest:

Name	Age	Sex	Grade in School	General Health

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Who referred you for the evaluation? ____

Child's pediatrician or family doctor ____

Address ____

Other doctor(s) treating the child ____

Is your child currently or have they previously received other therapy services (i.e. early childhood intervention or school based therapy?

☐Yes ☐No

If yes, please list location and areas of need being addressed : ____

BIRTH HISTORY

Pregnancy: ☐Normal ☐Abnormal/Complications (explain) ____

____

Length of Pregnancy ______ Premature: ☐No ☐Yes

Birth weight: ____lbs. ____ oz.

List any complications at delivery? ____

Did your child experience any complications immediately following birth? ☐ No ☐ Yes (explain):

____

DEVELOPMENTAL HISTORY

In early childhood, did child have any feeding/swallowing problems (such as poor control of sucking, food allergies, and/or digestive upsets)?

☐Yes ☐No

If yes, please describe: ____

Please list ages at which your child met the following developmental milestones:

Rolling (back to stomach/stomach to back): ____________

Sitting unsupported: ____________

Crawling: ____________

Standing unsupported: ___________

Walking: ____________

Eating solid foods: ________________

Self-feeding : finger - feeding ___________ using spoon/fork: ___________

Self-dressing: lifting arms/stepping in to pants ___________ dressing self independently ____________

Bladder/bowel control: Tells you when needs to go ________ sits on toilet independently ________ manages clothing_______ wipes self _______

Do you feel that your child was late or had difficulty in the development of these skills?

☐Yes ☐No

If so, please explain: ____

____

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EDUCATION HISTORY

Current School: ____

Grade: ____

Describe performance in school (please note areas of strength and need):

____

____

Does your child currently receive special education or accommodations under 504? (such as speech, occupational, or physical therapy, resource or inclusion time, special education classroom)? ☐ Yes ☐ No

If yes, please describe:

____

____

BEHAVIOR/SELF REGULATION

Are you concerned with your child's social skills? ☐ Yes ☐ No If yes, please explain :_________________________

____

Does your child prefer to play alone?

Does your child have a close friend? ☐ Yes ☐ No

Does your child have difficulty staying focused? ☐ Yes ☐ No

Describe how your child interacts with his/her peers: ☐ Yes ☐ No If yes, please explain: __________________________

____

____

____

How does your child respond to discipline? What is/is not effective?

____

____

What are your behavioral concerns?

____

____

Does your child appear to have difficulty regulating their emotions? If so, please describe:

____

____

Do you have any concerns regarding sensory processing including seeking and/or sensitivity to sensory input? If yes, please describe: ____

____

____

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MEDICAL HISTORY

Has your child been diagnosed by a physician with any medical diagnosis or conditions?

Is the child currently taking any medications? ☐ Yes ☐ No

If yes, please list: ______________________________

Does your child have any allergies (food, medicine, or seasonable such as hay fever, etc.)? ☐ Yes ☐ No

If yes, please describe: ______________________________

____

Has hearing been tested? ☐ Yes ☐ No If yes, when? ______________________________

Results: ______________________________

Has the child ever had ear (PE) tubes inserted? ☐ Yes ☐ No

If yes, when? ______________________________

Does your child currently have or have they ever had a cerebral shunt? ☐ Yes ☐ No

Does your child wear eyeglasses or have they had any difficulty with their eyes/vision? ☐ Yes ☐ No

If yes, please describe: ______________________________

Has your child seen a specialist for any reason? ☐ Yes ☐ No If yes, please explain:

____

OCCUPATIONAL HISTORY

Current areas of concern (Please check all that apply and include specific concerns):

☐ Fine Motor Skills - ______________________________

This could include:

- Object manipulation & use of tools (picking up and playing with toys and objects of various sizes; using tools for School including scissors, glue, writing utensils, etc...
- Strength
- Coordination/Dexterity

☐ Gross Motor Skills - ______________________________

This could include:

- Accessing all environments including home, school, and community (i.e playground) with or without the use of an assistive device (such as walker or wheelchair)
- Crawling, walking, running
- Strength, balance, endurance

☐ Self-Care - ______________________________

This could include:

- Dressing
- Feeding- self feeding, sensory aversions to food, oral motor control
- Bathing
- Grooming

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☐ Play - ____

- Social interactions
- Developmentally appropriate play

☐ Sensory Processing/Regulation - ____

☐ Emotional/Behavioral Concerns - ____

ENVIRONMENTAL FACTORS, HABITS, AND ROUTINES

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? ____

Does your child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Which language does the child prefer to speak at home? ____

What does your child enjoy and how do they like to play? ____

____

____

What are your child's typical habits and routines?____

____

____

____

____

Patient or Parent/Guardian Signature
(Printed Name Will Count as Signature)

____

Relationship to Patient

____

Date

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