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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

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: _____

_____

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? ☐ Yes ☐ No

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

Does your child have difficulty staying focused? ☐ Yes ☐ No If yes, please explain: _____

Describe how your child interacts with his/her peers:

_____

_____

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:

_____

_____

_____

MEDICAL HISTORY

Has your child been diagnosed by a physician with any medical diagnosis or conditions? ☐ Yes ☐ No

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

☐ 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