SENSORY CONNECTIONS

PEDIATRIC OCCUPATIONAL THERAPY

Background Information: Children

Date_____

I. General Information

Parent/Guardian Name:_____

(first) (last)

Child's Name:_____

(first) (last)

Birth Date:_____ Gender: Male_____ Female_____

Address:_____ City/State/Zip:_____

Phone Numbers (home, work, cell):_____

Permission to Contact/Leave Message ____ yes ____ no Permission to Communicate via Text: ____ yes ____ no

Email Address:_____ Permission to Communicate via Email: ____ yes ____ no

Emergency Contact Person:_____

(name) (relationship) (phone number)

Physician:_____ Referred by:_____

(name) (phone number)

Brothers/Sisters_____

School or Preschool Attended:_____ Grade in School:_____

Primary Insurance Information

Insured's Name: _____

Insured's Address: _____

Street/Box # City State Zip

Insured's Social Security #: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

Insurance Company: _____ Insurance ID #: _____ Group #: _____

Secondary Insurance Information

Insured's Name: _____

Insured's Address: _____

Street/Box # City State Zip

Insured's Social Security #: _____ Insured's Date of Birth: _____

Insured's Employer: _____ Relationship to Patient: _____

Insurance Company: _____ Insurance ID #: _____ Group #: _____

II. Medical Information

Medical Diagnosis (If any):_____

Medications taken:_____

Does your child have any of the following	___Speech / Language disorders_____
___ Attention Deficit (Hyperactivity) Disorder	___ Food allergies/special diet_____
___ Autism	___ Muscular weakness_____
___ Asperger's Syndrome	___ Seizures / Epilepsy_____
___ Pervasive Developmental Disorder	___ Vision problems_____
___ Tourette's Syndrome	___ Hearing problems_____
___ Learning Disabilities	___ History of ear infections_____
___ Bipolar Disorder	___ Tubes in ears_____
___ Anxiety	___ Allergies or asthma_____
___ Depression	___ Allergies (latex, medication):_____
___ Posttraumatic Stress Disorder	___ Stomach or intestinal problems:_____
___ Panic attacks	___ Casts or braces:_____
___ Obsessive Compulsive Disorder	___Surgery:_____
___ Attachment Disorders	___ Serious injury:_____
___ Other mental health disorder	___Other:_____

Describe any hospitalizations.:_____

Has child had vision test? Yes/No Results? _____ Has child had hearing test? Yes/No Results?_____

Child's height _____ Child's weight _____

Has child been seen by occupational therapy in the past? If so, when, where and for what reason:_____

_____

Please list and include reports from other evaluations or treatments your child has received (psychologist, PT, neurologist, OT, etc.)

Type Professional's Name Date

_____

_____

_____

_____

_____

III. Birth History

1. Were there problems or complications during pregnancy, delivery, or after birth?: ___Yes ___ No Please describe:

_____

_____

2. How many weeks old was your child when born (was birth early or late?)_____

3. At birth, were there inductions? ___Yes ___No At birth, were forceps/suction/vacuum used? ___Yes ___No

4. Was there a C-section? ___Yes ___No If yes, was it planned? ___Yes ___No

5. At birth, were there any complications such as:

Breech (feet first) ___Yes ___No Difficulty breathing ___Yes ___No

Fractures ___Yes ___No Jaundice ___Yes ___No

Bruising ___Yes ___No Cord around neck ___Yes ___No

6. Was child in intensive care or hospitalization after birth? ___Yes ___No If yes, for how long?_____

7. Was your child adopted? ___Yes ___No If yes, child's age at adoption_____

If yes, adoption was: ____Domestic _____International: what country_____

Please identify any important details of adoption, adjustment to new home, particular challenges with adoption, etc.

_____

_____

_____

IV. Childhood and Developmental History

1. Did child crawl? ___Yes ___No If yes, did child crawl with knees off the floor? ___Yes ___No

If yes, was crawling phase brief? ___Yes ___No Did child drag a leg? ___Yes ___No

Did child scoot instead of crawl? ___Yes ___No Did child slide? ___Yes ___No

2. Is child toilet trained in bowel and bladder? ___Yes ___No Does child have accidents? ___Yes ___No

3. Please give approximate ages when milestones were met, or comment on anything unusual

Roll over_____ Crawl_____ Chew solid food_____ Say words_____

Sit alone_____ Walk_____ Drink from cup_____ Say sentences_____

4. Is there difficulty with: ___ falling asleep ___ staying asleep ___ frequent night waking

5. How does child calm/soothe self?

_____

_____

_____

V. School

1. If in school, are there difficulties at school with any of the following?

____Reading ____Math ____Spelling ____Getting along with peers

____Handwriting ____Organizing work ____Remembering information ____Restlessness

____Finishing tasks ____Paying attention ____Following directions ____Social skills

2. Are there any problems with coloring, cutting, or using materials with hands?_____

_____

3. If in preschool or daycare are there any difficulties learning colors, letters, numbers, sitting in circle time, peer relationships, and/or beginning reading work (as appropriate for age of child)? Please circle. _____

_____

4. Are there any specific problems?_____

_____

5. Does child receive special services at school, have an Individual Education Plan (IEP) or a 504 plan? ___Yes ___No

If yes, please describe:_____

_____

_____

_____

VI: General

What are your concerns, needs, or goals for therapy?_____

_____

_____

_____

What are your child's greatest strengths? _____

_____

_____

_____