Mainely Kidz PT
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OT / PT Case History Form

Person completing this form: _____ Date:_____

Relationship to child: _____

PATIENT INFORMATION

Child's name: _____ Date of Birth:_____
Grade:_____ School: _____
Any other services they are receiving: ___PT ___OT ___CDS ___BHP ___HCT
Please list any other: _____
Adaptive equipment used: _____

Does your child have a diagnoses: Yes____ No_____ If yes please check all that apply.

Autism_____
ADHD_____
Sensory integration or sensory processing disorder_____
Cerebral palsy____
Down Syndrome_____
Developmental Coordination Disorder_____
Torticollis_____
History of fractures _____
Other_____

FAMILY INFORMATION

Mother's name:_____
Father's name:_____
Sibling(s): _____ Age:_____
_____ Age:_____
_____ Age:_____

Developmental and Medical History

Briefly describe why you are pursuing an occupational/physical therapy evaluation for your child:

_____
_____
_____
_____
_____
_____
_____

PREGNANCY/BIRTH HISTORY

Pregnancy: Full-term? _____ Premature? _____ Weeks gestation? _____
Type of delivery: Vaginal _____Cesarean Section _____ Why? _____

Complications during pregnancy? (bleeding, high blood pressure, infections, diabetes, etc.)
_____

Birth		Comments
1. Was your child alert with normal muscle tone and color at birth?	YES NO	
2. Were there medical complications at birth affecting heart, lungs, kidneys, or digestive organs? Please explain.	YES NO	
3. Were there any congenital defects affecting the limbs, face, nerves, other body parts? Please explain	YES NO	
4. Were there complications such as: cyanosis, jaundice, or limpness? Please specify.	YES NO	
5. Was there a need for oxygen, transfusions, IV, or tube feedings?	YES NO	
6. Did the child spend extra time at the hospital or time in a special nursery?	YES NO	
7. Was the child bottle or breast-fed? Please circle.	BOTTLE BREAST-FED	
8. Were there any feeding complications? Please specify.	YES NO	
Describe your child as an infant:		Comments
1. good, non-demanding	YES NO	
2. cried a lot, fussy, irritable	YES NO	
3. was alert	YES NO	
4. was active	YES NO	

5. was passive	YES NO	
6. liked being held	YES NO	
7. liked being rocked	YES NO	
8. was tense when held	YES NO	
9. was floppy when held	YES NO	
10. slept through the night easily	YES NO	
11. had irregular sleep patterns	YES NO	
Developmental Milestones	**Age**	Comments
1. roll over both ways		
2. sit independently		
3. crawl on hands and knees		
4. cruise around furniture		
5. walk independently		
6. speak first word		
7. drink from a cup without a lid independently		
8. use a spoon independently		
9. demonstrate hand preference		Circle: Left Right
10. put on shirt independently		
11. button independently		
12. dress independently		
13. ride a tricycle		
14. ride a bicycle without training wheels 15. pump a swing		
16. learn to tie shoelaces		
Describe Your Child in the Present		Comments
1. mostly quiet	YES NO	
2. talks constantly	YES NO	
3. overly active	YES NO	

4. tires easily	YES	NO
5. impulsive	YES	NO
6. restless	YES	NO
7. stubborn	YES	NO
8. resistant to changes	YES	NO
9. over-reacts	YES	NO
10. fights frequently	YES	NO
11. often happy	YES	NO
12. frequent temper tantrums	YES	NO
13. falls often	YES	NO
14. clumsy	YES	NO
15. has difficulty separating from primary caregiver	YES	NO
16. wanders off without caution	YES	NO
17. has nervous habits or tics (Please specify)	YES	NO

What are your greatest concerns for your child relative to his/her development and occupational / physical therapy?

_____
_____
_____

What are your child's strengths?

_____
_____
_____

What are your child's favorite activities/interests?

_____
_____
_____

Please comment on your child's behavior.

_____
_____
_____

Does your child behave differently at home than in other settings? Please describe.

_____
_____
_____

Is there anything else you would like your OT / PT to know about your child?

_____
_____
_____

Has your child seen the following specialist? If so, please give the approximate date and the examining person's name.

	By Whom	Date
Neurology		
Psychiatry		
Psychology		
Education		
Speech and Hearing		
Other special examinations		
Gentetics		
ENT		
Cardiology		
Other:		