PLANO THERAPEUTIC SERVICES

OCCUPATIONAL AND SPEECH THERAPY FOR CHILDREN

www.PlanoTherapeuticServices.com

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DEVELOPMENTAL AND SENSORIMOTOR HISTORY

Today's Date: _____

Child's Name: _____ Birth date: _____

Address: _____

Person Completing Form: _____Relationship: _____

Email Address: _____

Who referred your child for Occupational Therapy?

Please state current concerns and reason for this referral:

FAMILY COMPOSITION:

Mother's Name: _____

Address: (if different from child's)_____

Home Phone: _____ work or cell phone: _____

Father's Name: _____

Address (if different from child's):_____

Home Phone**:** _____ Work or cell Phone: _____

Siblings/others living at home:

Name Age

FAMILY HISTORY

Is there a significant family history of any of the following?

	YES	NO	WHO? RELATION TO CHILD?
Sensory Processing Disorder			
Speech Delay or Disorder			
Language Delay or Disorder			

Learning Disabilities			
Physical Challenges			
Genetic abnormalities			
Autism/Asperger's/PDD			
ADD			

PREGNANCY, LABOR and DELIVERY:

Is your child adopted? _____

Were there any complications during the pregnancy for this child? Yes/no

If so please describe:

Length of pregnancy: _____

Was delivery vaginal or caesarean section (planned or emergency?)

Child's birth weight: _____ Apgar Scores, if known: ____

Were there any complications during labor and delivery? If so, describe:

Did the baby have fetal distress? yes/no
Did the baby require intensive care treatment? yes/no
If yes, please describe the course of treatment

EARLY LIFE:

How would you describe the child's temperament as a newborn? easy? fussy? quiet? happy? hard to console?

How did you console him/her? (note what sensory calming strategies were effective, such as rocking)

SLEEP HABITS

As an infant, did this child have difficulty establishing sleep/wake cycles? yes/no

Does the child take a nap, appropriate for age? yes/no

At what age did the child give up taking naps?

How does the child put him/herself to sleep?

Where does the child sleep?

Does the child sleep through the night? yes/no most of the time

If he/she wakes up, how does he/she go back to sleep?

List any questions or concerns you have about your child's sleep habits

FEEDING HABITS

How was this child fed as a newborn? breast/bottle/other

Did the child have difficulty transitioning from breast to bottle? yes/no/NA

Did the child have difficulty transitioning to table foods or spoon feeding? yes/no
If so, what strategies were used?

Does the child feed him/herself? yes/no What utensils does he/she use? spoon/fork/knife

Did the child have difficulty transitioning from bottle to cup drinking? yes/no/NA

Is the child able to drink from a straw? yes/no

Does the child eat a good variety of foods, or is he/she a picky eater?
If yes, what foods does the child eat?

Is the child on a special diet? yes/no
If yes, what foods are avoided?

Does the child eat regular meals with the family? yes/no

List any questions or concerns you have about your child's eating habits:

Does the child have food allergies?: (please list) **Please make us aware of any severe food allergies**

Dressing skills:

Does the child dress him/herself, appropriate for age?

Please describe any concerns you have about your child's dressing skills:

At what age did your child dress independently_____
button_____tie shoes_____

MEDICAL HISTORY

Name of family physician or pediatrician: _____

Address: _____ Phone: _____
Has the child been seen by a neurologist or developmental specialist? If so, please give name and contact information:

Describe evaluation results (or bring a copy of the report to the OT assessment):

Does your child have a medical diagnosis? Yes/no:

If yes, please describe diagnosis and treatment:

Please list any ongoing health concerns:

Are the child's immunizations up to date? Y or N If not, please indicate the reason:

Has the child had any adverse reactions to immunization? Yes or No. If so, please describe:

Current Medications	**Reason taken**	**Amount**	**Times Daily**

Has the child had any major illnesses? Y or N If yes, please describe:

Has the child had any hospitalizations? Y or N If yes please describe below:

Illness/Accident	**Date**	**Length of Stay**	**Results**

Does the child have a history of ear infections? Y or N

If yes, how many? _____ How were the ear infections treated?

If your child has received any OT/ST/PT evaluations or treatment by any other professionals, please list provider, dates of services, and details:

DEVELOPMENTAL HISTORY

At what age (approximately) did the child:
sit alone_____creep/crawl_____walk_____
ride a bicycle with training wheels_____
ride a bicycle without training wheels_____
complete toilet training/day_____Night_____

SPEECH AND LANGUAGE HISTORY

At what age did the child begin to use single words?

Please describe any concerns about your child's speech and language development.

PLAY HISTORY
What is the child's favorite play activity?

Does the child have difficulty making friends?

Does the child prefer to play with siblings or friends, or to play alone?

Does the child prefer to play with children who are older or younger?

How many hours per week does the child:
play videogames?_____
watch TV?_____
play outdoors?_____
Is the child in any organized sports programs? yes/no
If so, what?

At the playground, what activities does the child prefer?

Are there any playground activities that your child avoids?

ACADEMIC HISTORY

Child's school/day care: _____Grade: _____

Teacher's Name: _____School Phone: _____
Please describe any concerns you have about your child academically:

Does the child enjoy school/preschool/daycare? yes/no describe concerns

Has the child had any behavior problems in school? yes/no
If yes, what?

Does the child receive any special services in school? yes/no
If so, what? How many hours per day or week?

VESTIBULAR (MOVEMENT) SENSORY PROCESSING:
Does the child:
1. seem overly cautious or fearful when moving. yes/no
2. seem to have poor balance for his age. yes/no
3. seem uncoordinated, and fall a lot, for his/her age yes/no
4. avoid movement activities?

Key: n=never (or rarely) s=sometimes a=always (or frequently) p= previously did, does not now
Does the child:
1. dislike being rocked n s a p
2. dislike being tossed into the air. n s a p
3. have fear in space (stairs, heights). n s a p
4. lose balance easily. n s a
5. like fast spinning carnival rides. n s a p
6. like to swing. n s a p
7. spin or whirl more than other children. n s a p
8. rock while sitting. n s a p
9. jump a lot. n s a p
10. get carsick easily. n s a p
11. get nauseous from other movement experiences. n s a p

Describe above responses, as needed:

TACTILE (TOUCH) SENSORY PROCESSING:
Does the child seem to have a normal response to people or things that touch him or that he touches? yes/no

Key: n=never (or rarely) s=sometimes a=always (or frequently) p= previously did, does not now

Does the child:

1. dislike being touched or cuddled. n s a p
2. prefer to touch rather than be touched. n s a p
3. avoid messy play, such as sand, water, fingerpaint. n s a p
4. avoid using his/her hands, preferring to look a objects instead. n s a p
5. dislike the feeling of certain clothing. n s a p
6. seem overly sensitive to food or water temperature. n s a p
7. seem excessively ticklish. n s a p
8. seem easily irritated when touched. n s a p
9. dislike having haircuts. n s a p
10. dislike having hair washed. n s a p
11. dislike the feel of lotion or sunscreen. n s a p
12. seem overly sensitive to food textures. n s a p
13. seem to lack the normal awareness of being touched. n s a p
14. often seem unaware of cuts, bruises, etc. n s a p
15. frequently bump or push others. n s a p
16. bang head on purpose. n s a p
17. have a strong need to touch objects or people. n s a p
18. examine objects or clothing with his/her hands. n s a p
19. mouth objects or clothing excessively. n s a p
20. seek certain strong tactile experiences; describe:

VISUAL PERCEPTION:
Does the child:

1. have a diagnosed visual problem yes/no
2. have trouble discriminating shapes, colors, letters yes/no
3. avoid eye contact. yes/no

Key: n=never (or rarely) s=sometimes a=always (or frequently) p= previously did, does not now

Does the child:

1. become easily distracted by visual stimuli. n s a p
2. make reversals when copying or reading. n s a p
3. seem very sensitive to light. n s a p
4. have trouble following with eyes. n s a p
5. hold his head to the side when looking at objects. n s a p
6. repeatedly seek out certain visual experiences. n s a p

Describe above responses, as needed:

TASTE AND SMELL PERCEPTION:

Does the child seem to respond appropriately to taste and smell? yes/no

Key: n=never (or rarely) s=sometimes a=always (or frequently) p= previously did, does not now

Does the child:

1. act as though all food tastes the same. n s a p
2. explore with taste. n s a p
3. chew on non-food items. n s a p
4. seem sensitive to smells. n s a p
5. explore objects by smelling them. n s a p
6. have strong food preferences or avoidances based on taste, smell, or texture? describe:
7. have any feeding problems? describe:

AUDITORY (SOUND) PERCEPTION:

Does the child have a diagnosed hearing problem or language delay? yes/no

describe:

Key: n=never (or rarely) s=sometimes a=always (or frequently) p= previously did, does not now

Does the child:

1. seem too sensitive to sounds. n s a p
2. respond negatively to unexpected sounds. n s a p
3. have fears of particular sounds. n s a p
4. seem distracted by sounds such as traffic sounds, air conditioner fan, furnace, etc. n s a p
5. miss some sounds or words. n s a p
6. seem to be confused about the direction of sounds. n s a p
7. like to make loud noises. n s a p
8. have difficulty following directions. n s a p
9. fail to listen to, or pay attention to, what is said to him/her. n s a p
10. have difficulty following two or three step directions. n s a p
11. talk excessively. n s a p
12. repeat songs more easily than spoken language. n s a p
13. become upset in noisy places such as stores or restaurants? n s a p

Describe above responses, as needed:

MUSCLE TONE:

Does the child seem to have average strength and coordination for his age. yes/no

Does the child have good endurance? yes/no

Key: n=never (or rarely) s=sometimes a=always (or frequently) p= previously did, does not now

Does the child:

1. seem “floppy” when he moves or runs. n s a p
2. seem “stiff” when he moves or runs. n s a p
3. get tired easily. n s a p
4. prefer to lie on back rather than tummy. n s a p
5. walk on his/her toes, rather than with heels down. n s a p
6. frequently lean on support or lie down, rather than support himself. n s a p

Does the child have any diagnosed muscle problems? describe:

COORDINATION:
Does/did the child have a delay in gross and fine motor skills? yes/no
Does the child have difficulty with fine or gross motor tasks? yes/no
Does the child have a preferred or dominant hand? yes/no Which? right/left/neither hand
Key: n=never (or rarely) s=sometimes a=always (or frequently) p= previously did, does not now
Does the child:

1. avoid fine motor activities? n s a p
2. avoid gross motor activities? n s a p
3. trip or fall a lot? n s a p
4. bump into things? n s a p
5. appear clumsy when playing? n s a p
6. handle small things with poor coordination for age? n s a p
7. have difficulty holding a pencil or crayon? n s a p
8. eat neatly for age? n s a p
9. appear shaky during fine motor tasks? n s a p

MOTOR PLANNING:

Key: n=never (or rarely) s=sometimes a=always (or frequently) p= previously did, does not now
Does the child:

1. have difficulty imitating actions or facial expressions of another person? n s a p
2. have difficulty imitating a sequence of actions, such as a nursery rhyme or action song? n s a p
3. avoid new motor activities? n s a p
4. take a long time to master new motor skills /learn to play with a new toy? n s a p
5. have difficulty combining new motor actions with ones previously learned? n s a p
6. seem "fearless", and not seem to anticipate danger? n s a p
7. play with toys only in one way? n s a p
8. fail to use gestures such as pointing, appropriate for age? n s a p

Describe any concerns about motor planning:

BEHAVIOR/TEMPERAMENT:
Does the child seem to have normal social and emotional development, for age? yes/no
Is the child being treated for a psychological or emotional problem? If so, please describe:

Does the child:

1. have a history of crying excessively in infancy? yes/no
2. frequently appear tense, anxious, easily frustrated? yes/no
3. seem explosive? yes/no
4. seem very active, in constant motion? yes/no
5. separate from parent, appropriate for age? yes/no
6. seem rigid, have difficulty adapting to change? yes/no
7. have difficulty playing alone, appropriate for age level? yes/no
8. have a short attention span? yes/no
9. get distracted easily? yes/no
10. have difficulty making choices? yes/no
11. have acting out, aggressive behavior? yes/no
12. have difficulty making friends? yes/no
13. prefer playing with children 1 or 2 years younger? yes/no
14. express feelings of low self-esteem? yes/no
15. express feelings of frustration? yes/no
16. seem discouraged yes/no
17. become easily upset or overwhelmed in groups? yes/no

Please add any additional information that you feel would be helpful in our evaluation of your child. Include information from other professional evaluations, teacher's comments or concerns, etc.

rev 2-12 P.Matzke and MP Bragers, adapted from Ayres, Oetter, Wilbarger