Occupational / Physical Therapy Case History

[Please fill out the following form to the best of your knowledge. By providing CTS with this information you are giving our therapists a chance to know your child and their needs better. This in turn allows CTS to provide them with the best possible care. You may omit any information that does not apply. Thank you for your time and help.]

Child's Name: ________________________________ Date of Birth: ____/____/____

Name and location of preschool or school attending:

____

Teacher: ____________________________ Grade: ________________ Age: ________

Reason for Assessment:

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Has your child ever received therapy? If so, please explain:

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Please list your child's strengths / best qualities:

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Are there any health or medical precautions? No ❒ Yes ❒

If yes, please list:

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Health History:

Pregnancy	Unremarkable ❒ Complications ❒
Birth	C-section ❒ Natural ❒ Any complications: Breast fed ❒ Birthweight: ______________________
Diagnosis or medical conditions	Yes ❒ (please explain): No ❒
Significant illnesses	What When
Surgeries	What When Precautions
Injuries	What When
Hospitalizations	Reason When
Medications/supplements (please list)	
Other medical/health information	

Hearing and Vision History:

Hearing	**Vision**
Hearing test completed Yes ❒ No ❒	Vision screening completed Yes ❒ No ❒
Results:	When? Results:
History of ear infections Yes ❒ No ❒ If yes, frequency: Tubes: Yes ❒ No ❒	Last visit to eye doctor: Doctor's name: Results: Glasses: Yes ❒ No ❒ Near sighted ❒ Far sighted ❒

Immediate relatives with known hearing loss? Yes ❒ No ❒ Relationship:	Does your child like writing? Yes ❒ No ❒ How is your child's handwriting: Does your child like reading? Yes ❒ No ❒ Does your child frequently fall? Yes ❒ No ❒
Irritated and/or unusually sensitive to noises Yes ❒ No ❒ Specific noises: Does your child like to make loud noises? Yes ❒ No ❒	

Feeding / Eating History:

(If your child has ever had problems with nursing, feeding, eating or drinking, please complete the following section)

Has your child ever had a feeding evaluation?	❒ Yes Results: ❒ No
What foods does your child enjoy? What are his/her favorite foods?	
What foods does your child struggle with?	
What does your child use to drink?	❒ Bottle ❒ Sipper cup ❒ Straw ❒ Cup ❒ Other ____________________
Does your child drool?	❒ Yes ❒ No Describe:
Does your child feed him/herself? If they do not feed him/herself, who feeds them?	❒ finger foods ❒ uses utensils
Where is your child fed?	❒ high chair

	❒ lap ❒ regular chair ❒ does not sit for meals
Please list any other feeding/eating concerns	

Self-Care Skills:

Dressing: When **dressing** my child is unable or needs help with:	
• Putting on pull over shirt	• Zipping pants
• Putting on jacket	• Starting a zipper on a jacket/coat
• Putting elastic waist pants/shorts	• Buttoning up a shirt or pants
• Putting on socks	• Buckling a belt
• Putting on Velcro or pull on shoes	• Snapping or unsnapping
• Buckling a belt	
Dressing: When **undressing** my child is unable or needs help with:	
• Taking off T shirt	• Taking off socks
• Unbuttoning shirt or pants	• Taking off shoes
• Taking off jacket	• Unbuckling belt
• Taking off elastic waist pants/shorts	Comments:
• Taking off pants with zippers, snaps, buttons, etc.	
Bathing/Grooming: When bathing/grooming my child is unable or needs help with:	
• Bathing/showering	• Brushing teeth
• Washing hands	• Combing/brushing hair
Comments:	

When going to the bathroom my child is:	
• Is NOT toilet trained	Comments:
• Uses the toilet without my help (clothing, hygiene, etc.)	

Physical Development and Play History:

At what age did your child?

Sit up
Crawl
Stand
Walk

Does your child:

Hop/jump on two feet	❒ Yes ❒ No
Hop on one foot	❒ Yes ❒ No
Kick a ball forward	❒ Yes ❒ No
Ride a tricycle Ride a bicycle	❒ Yes ❒ No ❒ Yes ❒ No
Jump sideways	❒ Yes ❒ No
Walk up steps with alternating feet	❒ Yes ❒ No
Walk down steps with alternating feet	❒ Yes ❒ No
Catch and throw a ball	❒ Yes ❒ No
Walk or run on his/her toes?	❒ Yes ❒ No

What are your child's favorite toys or play objects?

Does your child participate in imaginary play?

How much screen time does your child have during the week/weekends? What games do they play?

Does he/she prefer to play alone or with friends?
Who are your child's playmates?

Is your child able to "entertain" him/herself or does he need someone to play with?

Please list regular school or social activities your child participates in:

Sensory Concerns: (If there are specific sensory processing concerns/issues please fill out The Sensory Profile which will be provided)

Do you have any observations or concerns about the following sensory systems? Please describe in the space below:

Sense	**Description**
Tactile (Touch)	
Auditory (Sound/hearing)	
Olfactory (Smell)	
Vision	
Gustatory (Taste)	
Vestibular (movement/balance)	

Social/Language History:
Primary language spoken: ___________________________

Please check any of the following that apply:

❒ Child does not speak clearly
❒ Child does not follow directions
❒ Child has trouble paying attention
❒ Child has trouble understanding
❒ Child has trouble remembering
❒ Child has trouble expressing self
❒ Child has trouble relating to others
❒ Child has trouble playing with others
❒ Child has difficulty adjusting to change
❒ Child seems sensitive to certain tastes or touch
❒ Child does not seek or use eye contact

Please provide descriptions of any of the concerns checked above:

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Have any of the above concerns gotten better or worse since you first noticed them?
Yes ❒ No ❒ if yes, please explain:

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_____________________________________ ______ / ______ / _______

Signature of Parent / Guardian Date