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Confidential Personal History

Today's Date: ____________________ Form Completed By: ________________________________

Child's Name: ____

DOB: __________________________ Current Age: ____________ Gender: ______________________

Address: ____

Home Phone: _______________________________

FAMILY INFORMATION

Parent's Name: ____

Occupation: _______________________________________

Address: ____

Home Phone: _______________________________ Cell/Work Phone: ___________________________

E-mail: ____

Parent's Name: ____

Occupation: _______________________________________

Address: ____

Home Phone: _______________________________ Cell/Work Phone: ___________________________

E-mail: ____

Parents' Living Situation: ____

Emergency Contact (name, number, relationship): ____

Siblings: ____ Age: _______ Grade: __________

____ Age: _______ Grade: __________

____ Age: _______ Grade: __________

SOCIAL HISTORY AND PERSONALITY PROFILE

School/Day Care: ______________________________ Grade: ____________

Teacher's Name: ______________________________ Phone: ____________

What are your child's strengths?: ______________________________

____

What do you enjoy about your child and family?: ______________________________

____

What are the presenting problems for your child? (All categories below need not apply)

Academic: ______________________________

____

Activities of daily life (ie. eating, dressing): ______________________________

____

Relationships: ______________________________

____

Sensory: ______________________________

____

Motor: ______________________________

____

Play: ______________________________

____

Other: ______________________________

____

What kind of interests and activities does your child have (hobbies, sports, clubs)? Please list them in order of preference beginning with the favorite activity.

____

____

____

MEDICAL INFORMATION

Physician: ______________________________________

Address: ____

Phone:____ Fax: _____________________________________

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

_______ ADD

_______ ADHD

_______ Anxiety Disorder or Mood Disorder (specify): ____

_______ Autistic Spectrum Disorder

_______ Cerebral Palsy

_______ Down Syndrome

_______ Dyslexia

_______ Emotional disorder (specify): ____

_______ Fragile X Syndrome

_______ Learning Disabilities (specify): ____

_______ Sensory Processing Disorder or Sensory Integration Dysfunction

_______ Tourette's Syndrome

_______ Other (specify): ____

Who provided each diagnosis and what criteria was it based on (i.e. test scores, comprehensive clinical evaluation, genetic study, etc.): ____

____

____

Are there any medical precautions the therapist should be aware of when working with your child?

____

MOTHER'S HEALTH DURING PREGNANCY

Please circle Yes or No to the following questions and remark in the space provided.

1. Were there any infections/illnesses during pregnancy? Yes No ___________________________________
2. Was there any unusual stress during pregnancy? Yes No ____
3. Were any drugs or medications taken during pregnancy? Yes No _________________________________
4. Was the pregnancy full-term? Yes No If no, number of weeks gestation: ______________
5. Was the labor normal? Yes No ____

6. Was the delivery normal? Yes No If no, please specify (cesarean section, breech, cord around neck, forceps used): ____

7. Was medication given during delivery? Yes No ____________________________

CHILD'S BIRTH

Please circle all that apply and/or fill in the blanks.

1. Child's weight at birth: ______________ Length of infant's hospital stay: ______________
2. Were there any complications? seizures jaundice congenital defects other: ______________

____

3. Was there a need for: oxygen transfusions tube feedings other: ______________________

____

4. Did your infant cry right away? YES or NO Apgar scores: 1 min ________ 5 min ________
5. Was the child breast fed or bottle fed? ____________ Age when weaned? ______________
6. Did the infant have any feeding problems? ______________________________
7. Describe your child's demeanor and behavior as an infant: ______________________

____

8. Please state any other difficulties or special concerns: __________________________

____

DEVELOPMENTAL MILESTONES

Please list the age (in months) at which your child did the following.

Roll ________ Sit ________ Belly Crawl ________ Crawl on hands/knees ________ Walk ________

Run ________ Skip ________ Say first word ________ Finger feed ________ Use spoon ________

Drink from cup ________ Dress independently ________ Bladder control ________ Bowel control ________

Any concerns or questions about your child's development? __________________________

____

CURRENT CONDITION

Date of last physical exam: __________ Current weight: __________ Current height: __________

Current Medications/Dosage/Frequency: ______________________________________

My child currently sleeps/naps (circle one): inconsistently well restless other

My child currently eats/drinks (circle): at regular / irregular intervals consistent / inconsistent amounts

Known Allergies/Diet Restrictions: ______________________________________

Are immunizations up to date? Yes No ______________________________

History of major illnesses/hospitalizations: ______________________________

History of ear infections: Yes No If yes, how many?: __________

Date of most recent hearing test: __________ Results: ______________________________

Where was the test conducted? ____ School ____ Doctor ____ Audiologist

Does your child wear hearing aids? Yes No Describe hearing loss: ____________________

Date of most recent vision screening: __________ Results: ______________________________

Please describe any vision impairment: ______________________________

Any mental, physical, developmental, or emotional diagnoses within the immediate family?

____

____

Current or ongoing concerns/reason for referral: ______________________________

____

PREVIOUS & CURRENT THERAPIES AND/OR SPECIALISTS

Please list names, types and dates seen. If applicable, please provide copies of relevant evaluations and reports (occupational therapy, speech-language therapy, psychoeducational, neurological, IEPs, etc.).

____

____

____

____

GOALS

What are your goals for your child's OT program? Please be as specific as possible.

1. ______________________________

   ____

   ____

2. ______________________________

   ____

   ____

3. ______________________________

4. ____

5. ____

PLEASE USE SPACE BELOW FOR FURTHER COMMENTS:

How did you hear about Allison Rooney, MOT, OTR/L___________________________________

If you were referred:

Referred By: ___________________________ Profession: ________________________________

Address: ____

Allison Rooney has my permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation.

Parent or Guardian: ____________________________ Date: ____________________________