



**Individual History Record**

Please complete the following individual history record as it applies to your child

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work / other: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Persons to be notified in case of Emergency: (other than Parents)**

Name: \_\_\_\_\_ Cell/ Work Number: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ FL Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax (if known): \_\_\_\_\_

Name of other Specialists treating child:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance information:**

Name of Policy Holder: \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy #. \_\_\_\_\_ Group #. \_\_\_\_\_

Secondary Insurance? Yes / No

Name of Policy Holder: \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy #. \_\_\_\_\_ Group #. \_\_\_\_\_

**Referral Information**

Who can we thank for referring you? \_\_\_\_\_

Please describe the reason for referral / diagnosis: \_\_\_\_\_

\_\_\_\_\_

What are your major concerns about your child? \_\_\_\_\_

\_\_\_\_\_

Has your child ever received occupational therapy services? If so, why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRENATAL HISTORY**

History of pregnancy with this child (medications, health of mother, complications, problems): \_\_\_\_\_

\_\_\_\_\_

Length of pregnancy (number of weeks): \_\_\_\_\_

Type of delivery/complications: \_\_\_\_\_

Previous pregnancies/complications: \_\_\_\_\_

\_\_\_\_\_

**ADOPTION:** (Complete **if appropriate**-otherwise proceed to the next session)

Please explain the circumstances surrounding the adoption: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Age Adopted: \_\_\_\_\_

Prior Homes: \_\_\_\_\_

Response to New Home: \_\_\_\_\_

Aware of Adoption: \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

**PARENT'S**

**MOTHER**

**FATHER**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Profession: \_\_\_\_\_

Profession: \_\_\_\_\_

Handedness (R or L): \_\_\_\_\_

Handedness (R or L): \_\_\_\_\_

Names, ages and hand dominance of the children in the family:

<u>NAME</u>	<u>AGE</u>	<u>R or L HANDED</u>
1. _____		
2. _____		
3. _____		

Did any of the children received therapy, special training or schooling? \_\_\_\_\_

Describe how the child gets along with parents and siblings? \_\_\_\_\_

How do you describe your child's **social skills**? \_\_\_\_\_

History of the family since the birth of the child (moves, changes, significant traumas, other significant factors): \_\_\_\_\_

Parents live together? \_\_\_\_\_

**Describe custody if necessary:** \_\_\_\_\_

**MEDICAL HISTORY**

Hospitalizations right after birth (NICU) length of stay: \_\_\_\_\_

Other Childhood Hospitalization (reason, age): \_\_\_\_\_

**Childhood illnesses (Check)**

Asthma _____	Measles _____	Tubes in Ears _____
Allergies _____	Pneumonia _____	Ear Infections _____
Mumps _____	Chicken pox _____	Frequent Colds _____
Seizures _____		

Any other medical information you feel we should be aware of: \_\_\_\_\_

Has a **neurologist** seen your child?      Yes      No

If yes, the Neurologist's name: \_\_\_\_\_

Results: \_\_\_\_\_

Has your child's **vision** been tested?      Yes      No

If yes, the ophthalmologist or optometrist's name: \_\_\_\_\_

Results: \_\_\_\_\_

Has your child's **hearing** been tested?      Yes      No

If yes, the audiologist name: \_\_\_\_\_

Results: \_\_\_\_\_

List any **medications** taken regularly: \_\_\_\_\_

Are there any other illnesses or medical conditions which have been **diagnosed**? \_\_\_\_\_

Please inform us of any other **therapies** the child receives and the frequency (PT, ST, and AVT)? \_\_\_\_\_

**DEVELOPMENTAL HISTORY** (Complete **appropriate sections** and proceed to the next session)

Condition of newborn (Apgar scores, weight, height, problems): \_\_\_\_\_

Feeding as an infant (method, eating patterns, problems): \_\_\_\_\_

Current eating habits: \_\_\_\_\_

Sleep (patterns, problems): \_\_\_\_\_

Activity level (reaction to being moved, degree of activity, child's favorite activity): \_\_\_\_\_

Toilet training (age, duration, problems): \_\_\_\_\_

**Developmental milestones - Age at which child completed the following:**

Rolled \_\_\_\_\_ sat alone \_\_\_\_\_ crawled \_\_\_\_\_

ran \_\_\_\_\_ walked \_\_\_\_\_ drank from a cup \_\_\_\_\_

used words \_\_\_\_\_ 2 word sentences \_\_\_\_\_ 3-4 word sentences \_\_\_\_\_

asked questions \_\_\_\_\_

Describe general fine motor and gross motor coordination: \_\_\_\_\_

Describe ability to communicate: \_\_\_\_\_

Describe any unusual behaviors or problems (head banging, temper tantrums, rocking, etc.): \_\_\_\_\_

**SELF CARE SKILLS** (Complete if appropriate-otherwise proceed to the next session)

Tolerates hygiene activities:

**Dressing:**

Undresses self \_\_\_\_\_ Dresses Self \_\_\_\_\_ Removes Pants \_\_\_\_\_ Puts on Pants \_\_\_\_\_  
Removes pullover shirt \_\_\_\_\_ Puts on Pullover Shirts \_\_\_\_\_ Orients shirt front / back \_\_\_\_\_  
Removes Shoes \_\_\_\_\_ puts on Shoes \_\_\_\_\_ Orients Shoes \_\_\_\_\_ Remove Socks \_\_\_\_\_ Puts on socks \_\_\_\_\_

**Fastens:**

Unlaces \_\_\_\_\_ laces \_\_\_\_\_ ties bows \_\_\_\_\_ Unzip front \_\_\_\_\_ zips back \_\_\_\_\_  
buttons large \_\_\_\_\_ unbuttons large \_\_\_\_\_ buttons small \_\_\_\_\_ unbuttons small \_\_\_\_\_  
buckles \_\_\_\_\_ unbuckles \_\_\_\_\_

**Self Care:**

Eats independently with: fork \_\_\_\_\_ Spoon \_\_\_\_\_ Knife \_\_\_\_\_ with no spillage \_\_\_\_\_  
washes and dry hands partially \_\_\_\_\_ fully \_\_\_\_\_  
Brushes teeth with assistance \_\_\_\_\_ brushes teeth without assistance \_\_\_\_\_

Toilets (knows when accidents occur) \_\_\_\_\_ Falls asleep on his/her own \_\_\_\_\_

Calms Down easily when upset \_\_\_\_\_

**EDUCATIONAL HISTORY** (Complete if appropriate-otherwise proceed to the next session)

Preschool (name and age started): \_\_\_\_\_

Present school and grade: \_\_\_\_\_

Type of class (structured, open, etc.): \_\_\_\_\_

**Teacher's comments** (anything the teacher told you about your child): \_\_\_\_\_

Comments your child 's teacher had made): \_\_\_\_\_

Performance at school (behavior, socialization, play patterns): \_\_\_\_\_

Does your child like school?    Yes        No        Grades (A), (B), (C), (D)

Classes he/she especially likes/dislikes: \_\_\_\_\_

Check any areas of difficulty or concern for your child:

Reading: \_\_\_\_\_    Conduct: \_\_\_\_\_    Completing Work: \_\_\_\_\_

Math: \_\_\_\_\_    Phys. Ed.: \_\_\_\_\_    Playground time: \_\_\_\_\_

Do you feel your child can organize work adequately? \_\_\_\_\_

List your concerns regarding school: \_\_\_\_\_

**ADDITIONAL INFORMATION**

Is there any other information you feel would be helpful as we evaluate your child? \_\_\_\_\_

Any other concerns: \_\_\_\_\_

What do you hope to learn from this evaluation? \_\_\_\_\_

Parent **GOALS** for Therapy: \_\_\_\_\_

The above information is, true and complete to the best of my knowledge.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

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New Policy: Effective September 1, 2011

The estimated patient's co-pay responsibility is based on usual and customary insurance fees contract rates. You will receive an explanation of benefits (EOB) from your insurance company designating their paid amount and/or your responsibility amount.

InterPlay Therapy will only charge your credit card if an additional amount is due after your insurance company has processed all your claims for that month. We will send you a statement. If no payment has been received within 14 days of the statement, we will charge your credit card the remaining balance for that month. You will receive an e-mail from InterPlay Therapy confirming the credit card was charged.

"We appreciate your business".

Name as it appears on the card: \_\_\_\_\_

Credit Card Type:      VISA / MasterCard / Amex      \_\_\_\_\_

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CVV \_\_\_\_\_  
(Code on the back of the card)

Signature: \_\_\_\_\_