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:** ____

Father / Mother's Name: ____ **Cell Number:** _________________________________

Father / Mother'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	PARENT	PARENT
Name:	____	Name: ____
Profession:	____	Profession: ____
Handedness (R or L):	____	Handedness (R or L): ____

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

NAME AGE R or L HANDED

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 their any other illnesses or medical conditions which have been **diagnosed**?______________________________________

____

Please informs 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 san 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**