OCCUPATIONAL THERAPY
CASE HISTORY / INTAKE FORM

CHILDS INFORMATION

Child's Full Name ______________________

Child's Nickname(s) ______________________

Child's Date of Birth ______________________

Chronological Age ______________________

Adjusted age (if applicable) ______________________

Street Address ______________________

City, State Zip ______________________

Home Tel ______________________

CAREGIVERS INFORMATION

Mother's Name ______________________

Mother's Occupation ______________________

Mother's Cell ______________________

Mother's Work Tel ______________________

Mother's Email ______________________

Father's Name ______________________

Father's Occupation ______________________

Father's Cell ______________________

Father's Work Tel ______________________

Father's Email ______________________

Alt Caregiver's Name ______________________

Alt Caregiver's Cell ______________________

REFERRAL

Referred By ______________________

Reason for Referral ______________________

Chatty Child
Speech & Occupational Therapy, PLLC

CURRENT STATUS / CONCERNS

Does your child have a medical diagnosis? If yes, please list.

____

____

What are your present concerns? Please list.

____

____

Have your concerns changed? Please explain.

____

____

Has the problem gotten better, worse or stayed the same in the last year?

____

____

What are your primary concerns with your child's fine motor/ gross motor development? Sensory needs?

____

____

SOCIAL HISTORY

With whom is the child living?

____

____

Please list names and ages of child's siblings (if applicable)

____

____

Who are the primary caregivers?

____

____

Creating Voices
One Child
At a Time.

325 Broadway - Suite 403, New York, New York 10007
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www.chattychild.com

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BIRTH EXPERIENCE

How was mother's pregnancy experience?

Any illness during pregnancy? Please list.

Any medications taken during pregnancy? Please list and explain.

What medical tests were taken during pregnancy? Please list and explain.

Any medications taken during pregnancy? Please list and explain.

Any alcohol or drugs used during pregnancy?

Length of pregnancy in weeks?

Duration of labor?

Type of delivery?

List any problems during labor and/or delivery:

Apgar Scores

Was respiratory supports needed?

MEDICAL HISTORY

List any medications your child is currently taking:

____

____

List any medications your child has taken in the past:

____

____

Any surgeries or medical interventions? If yes, please explain.

____

____

Has your child experienced any of the following, if so please describe:

Ear Infection ______________________________

Allergies ______________________________

Asthma ______________________________

High Fevers ______________________________

Seizures ______________________________

Frequent Upper Respiratory Infections ______________________________

Pheumonia ______________________________

Other illnesses (list) ______________________________

Genetic Testing ______________________________

Neurological Testing ______________________________

Medical Diagnosis

____

Does your child experience regular bowel movements? ______________________________

Is your child toilet trained? ______________________________

MOTOR MILESTONES

When did your child first:

Roll Over (did your child roll both ways) ______________________________

Sit up ______________________________

Crawl ______________________________

Walk ______________________________

Run ______________________________

Jump ______________________________

What is child's hand preference? ______________________________

Describe any fine motor concerns.

____

____

Describe any gross motor or physical concerns.

____

____

Describe any Sensory concerns.

____

Does your child like/ dislike messy play? ______________________________

____

Does your child avoid certain thing/ equipment on the playground? ______________________________

____

Does your child demonstrate any hyper or lethargic behaviors? ______________________________

____

How does your child communication his or her needs? ______________________________

____

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SPEECH AND LANGUAGE

How does your child communication his or her needs? ______________________________

____

Does your child answer questions easily or with difficulty?

____

Does your child follow directives easily or with difficulty?

____

Does your child communicate with gestures, words, or sentences?

____

Describe any speech concerns you may have?

____

____

SLEEP PATTERNS

What is child's usual bedtime and rise time? ______________________________

Does your child still nap? For how long? ______________________________

Any sleep problems? Describe your child's sleep patterns.

____

____

Is your child irritable? If so, at what times? ______________________________

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CHILD'S PERSONALITY

Describe child's likes:

____

____

Describe child's dislikes:

____

____

What toys does your child enjoy?

____

____

What fears does your child have?

____

____

What does your child find frustrating?

____

____

How is your child disciplined?

____

____

What kinds of things can the child do for him/herself?

Dressing	Eating
Bathing	Fasteners (buttons, zippers, etc.)
Toileting	Other

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