O.T. 4 kids, Inc.

## General Information

| | |
|---|---|
| Child's Name: | Birth Date: |
| Reason for Referral: | Parents Primary Concern: |
| What is the primary language spoken at home? | Are there any other languages spoken or taught? |
| Name of School: | Grade: |
| Does your child have difficulty with any of the following? Circle all that Apply:<br>- Reading<br>- Following Directions<br>- Finishing Tasks<br>- Handwriting<br>- Paying Attention | - Handwriting<br>- Paying Attention<br>- Restlessness<br>- Math<br>- Remembering Information<br>- Spelling<br>- Organizing Work |

| |
|---|
| What do you hope to gain from this evaluation and/or treatment? |
| |
| What particular skill would you like your child to develop? |
| |
| Do you or anyone else in your family have similar difficulties to your child's? If so, please describe below. |
| |
| When were the problems first noticed? By Whom? |
| Has the problem changed since it was first noticed? |

## Birth History (Mother's Pregnancy)

| | |
|---|---|
| Child's Birth Height: | Child's Birth Weight: |

| | Yes | No | Explain |
|---|---|---|---|
| Was your child born full term? | | | |
| Were there complications during pregnancy? | | | |
| Were there complications during labor or delivery? | | | |
| Was your child adopted? | | | |

## Medical History and Information

Has your child had a hearing test? Yes ____ No _____ Dates: _____ Results: _____

Has your child had a vision test? Yes ____ No _____ Dates: _____ Results: _____

Need glasses? Yes _____ No _____ What for? _____

Has your child had any of the following?

| | Yes | No | Explain |
|---|---|---|---|
| Childhood diseases? | | | |
| Major illnesses? | | | |
| Congenital abnormalities? | | | |
| Illnesses? | | | |
| Surgery? | | | |
| Serious injuries? | | | |
| Ear infections? | | | |
| Tubes in ears? | | | |
| Seizures? | | | |
| Hospitalized? | | | |
| Other?<br>- Any other medical precautions that the therapist should be aware of when working with your child?<br>- Is there any information that you are uncomfortable saying in front of your child? | | | |

| Current Medications | Reason for Medication |
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## Developmental History

| Developmental Milestones: | Approximate Age Reached: | Comments or any unusual habits: |
|---|---|---|
| Roll Over | | |
| Sit Alone | | |
| Chew solid food? | | |
| Drink from a cup? | | |
| Say words? | | |

| | | |
|---|---|---|
| Say sentences? | | |
| Crawl?<br>Was the crawling phase brief?<br>Yes _____ No _____ | | |
| Walk?<br>Did your child use a walker?<br>Yes _____ No _____ | | |

In the past or currently, did/does your child…

| | Yes | No | Explain |
|---|---|---|---|
| Have feeding problems? | | | |
| Have sleeping problems? | | | |
| Have colic? | | | |
| Prefer certain positions as an infant? | | | |
| Dislike lying on stomach or back? | | | |
| Enjoy bouncing? | | | |
| Become calmed by car rides or infant swings? | | | |
| Become nauseated by car rides or infant swings? | | | |
| Tend to be compliant? | | | |
| Go through the “terrible twos"? | | | |

**Self Care and Daily Living Skills**

| | Yes | No | Explain |
|---|---|---|---|
| **TOILETING:** | | | |
| Independent/ Dependent on Caregiver | | | |
| Wipes Independently? | | | |
| Aware when wet or soiled or asks to be changed? | | | |
| Accidents during the day or night? | | | |
| Was toilet training delayed? Specify: | | | |
| Tend to masturbate frequently? | | | |
| **SLEEP PATTERNS:** | | | |
| Have irregular sleep patterns? | | | |
| Sleeps through the night? | | | |
| Sleeps in own bed? | | | |
| Tend to be an early riser or difficult waking up? Specify: | | | |
| Have difficulty falling asleep? How long? | | | |
| Naps? How often? | | | |

| | | | |
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| **DRESSING:** | | | |
| Able to undress independently? | | | |
| Able to dress independently? | | | |
| Able to manipulate fasteners? (Buttons, zippers, buckles) | | | |
| Knows orientation of clothing and shoes? | | | |
| Sensitive to fabrics, tags, socks, shoes, etc.? | | | |
| Tie shoes independently? | | | |
| Tend to wear incorrect clothing for season? | | | |
| **BATHING/ GROOMING:** | | | |
| Shower or bath? Circle One. | | | |
| Requires supervision or safety concerns? | | | |
| Able to wash self independently? | | | |
| Able to wash hair independently? | | | |
| Afraid of water on head or face? | | | |
| Afraid of lying back? | | | |
| Aware of temperature? | | | |
| Allows haircuts? | | | |
| Allows hair brushing? | | | |
| Allows face washing? | | | |
| Allows nail trimming? | | | |
| Brush teeth independently? | | | |
| Spit out toothpaste independently? | | | |
| **FEEDING/ ORAL:** | | | |
| Child is able to: circle the following:<br>- Blow bubbles<br>- Blow on whistles<br>- Blow up a balloon | | | |
| Picky Eater? | | | |
| Increased Gag? | | | |
| Overstuffs? | | | |
| Messy Eater? | | | |
| Use of Utensils independently? | | | |
| Able to suck through a straw? | | | |
| Drinks from an open cup? | | | |
| Able to sit through meals at home and/or restaurants? | | | |
| Use a knife to cut? | | | |
| Frequently spilling liquids? | | | |
| Grind teeth frequently? | | | |
| Have trouble chewing? | | | |

| | | | |
|---|---|---|---|
| Drool without noticing? | | | |
| Grimace or move tongue while doing fine motor tasks? | | | |
| **SAFETY AWARENESS:** | | | |
| Risk Taker/ Hesitant? | | | |
| Environmental Awareness? | | | |
| Impulsive? | | | |
| Understands and Respects Spatial/Personal Boundaries and/or aware of others and objects in space? | | | |
| **PAIN AWARENESS:** | | | |
| Overly emotional/ dramatic to minor injuries? | | | |
| Lacks reaction to pain? | | | |
| Pinch, bite, or otherwise hurt self; such as head banging? | | | |
| Unable to identify where hurt? | | | |
| Seems oblivious to bruises and heavy falls? | | | |
| **LANGUAGE:** | | | |
| Have trouble remembering what was said? | | | |
| Have speech or articulation difficulties? | | | |
| Have trouble expressing what he or she wants? | | | |
| Need frequent repetition of directions? | | | |
| Have difficulty localizing sounds? | | | |
| How does your child communicate? Circle:<br>- Gestures<br>- Signing<br>- Talking; single words, multiple words, naming objects, sentences? | | | |
| Use simple questions? | | | |
| Engage in conversation? | | | |
| **SOCIAL:** | | | |
| Tend to prefer playing alone? | | | |
| Prefer to play with other children? | | | |
| Prefer to play with children who are 1 to 2 years younger? | | | |
| Have a strong desire for sameness or routine? | | | |
| Tend to crave attention? | | | |
| Tend to be aggressive? | | | |
| Tend to be quiet? | | | |
| Lack of carefulness, and /or impulsive? | | | |

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|---|---|---|---|
| Tend to be impatient, easily frustrated, or stressed? | | | |
| Has difficulty separating from parents? | | | |
| Prefer the company of adults to children? | | | |
| Dear poorly with unstructured time? | | | |

**Hobbies/ Extracurricular/Play**

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|---|---|
| What are your child's favorite play things? | |
| What does he or she do with these toys/objects? | |
| What activities does your child least enjoy? | |
| Are there any things which your child fears or avoids? | |
| Does your child play with things by lining or piling them up? | |
| What extracurricular activities is your child involved in? (i.e. sports, clubs, etc.) | |

**Motor Skills and Motor Planning**

| | Yes | No | Explain |
|---|---|---|---|
| **FINE MOTOR COORDINATION:** | | | |
| Seem shaky when doing fine motor tasks? | | | |
| Have an awkward grasp with a pencil or crayon? | | | |
| Have poor handwriting? | | | |
| Experience fatigue in hand with writing? | | | |
| Can write name? | | | |
| Play with puzzles? | | | |
| Build with rocks, legos, or other materials? | | | |
| Color inside the lines? | | | |
| **GROSS MOTOR COORDINATION:** | | | |
| Perform activities too slow or too fast? | | | |
| Seems clumsy and/ or awkward? | | | |
| Appear to be reluctant to participate in sports and games? | | | |
| Have difficulty with motor tasks which have several steps? | | | |
| Difficulty jumping with one or both feet? | | | |
| Difficulty learning to skip? | | | |
| Difficulty using riding toys with feet pushing or propelling? | | | |
| Often seems overly active or moves too slowly? | | | |

| | | | |
|---|---|---|---|
| Have difficulty petting animals, tend to use too much force? | | | |
| Likes to spin, twirl, and or run repetitively? | | | |
| Roller Skate? Ride a bike? Uses training wheels? | | | |
| Jump rope? | | | |
| Kick a ball? | | | |
| Swim? With floaties? | | | |
| Avoid swings and/or slides? | | | |
| Become upset at being tipped upside down or lifted overhead? | | | |
| Hesitate or avoid climbing on equipment such as jungle gyms? | | | |

**Sensory History**

| | Yes | No | Explain |
|---|---|---|---|
| Does your child seek excessive touch or resist touch by others? | | | |
| Seems excessively ticklish? | | | |
| Dislike wearing band aids or stickers? | | | |
| Avoid getting hands into paste, messy things? | | | |
| Overheat easily? | | | |
| Become car sick easily? | | | |
| Become easily distracted by visual stimulation (such as movement or light)? | | | |
| Engage in “staring” behavior on sparkly, spinning, lighted and/or reflective objects? | | | |
| Has a fear of catching balls? | | | |
| Difficulty copying from paper to paper or blackboard? | | | |

Signature Relationship Date