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SPEECH THERAPY

OCCUPATIONAL THERAPY

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OT FORM

Behavior/Social History

Please check if your child has had any of the following:

Difficulty paying attention:	_____	Difficulty with transitions:	_____
Poor coping skills:	_____	Difficulty with new people:	_____
Difficulty with self-calming:	_____	Difficulty with turn taking:	_____
Tantrums:	_____	Plays well with other children:	_____
Difficulty following directions:	_____	Makes good eye contact :	_____
Difficulty in new places:	_____	Understands safety:	_____
Does not like crowds:	_____	Does well with change:	_____

Comments:

_____

_____

Do you have any concerns about:

- ☐ Fine Motor Control (i.e. difficulty holding a pencil, self-feeding, utilizing scissor):
- ☐ Gross Motor Control (i.e. throwing a ball, walking up/down stairs, jumping, climbing):
- ☐ Visual Perception (i.e. completing puzzles):
- ☐ Cognitive (memory, problem solving):
- ☐ Sensory processing:
- ☐ Behavioral:

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What are your primary goals for Occupational Therapy?

Has your child previously received ABA, occupational, physical, or speech therapy? What was the focus? Please include where, when, and for how long:

Is your child currently receiving any of these therapy services? Please list locations and frequency:

What kind of classroom? (i.e. inclusion, mainstream, LLD, multiple disability, self-contained):

Does your child have an IEP? ☐ YES ☐ NO

Does your child have a 504? ☐ YES ☐ NO

What services or accommodations does your child receive at school through the IEP/504?

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	Independent (completes without help)	I assist 50% or more	Dependent (total assistance needed)
Puts shirt on			
Takes shirt off			
Puts pants on			
Takes pants off			
Puts socks on			
Takes socks off			
Puts shoes on			
Takes shoes off			
Managing shoe laces			
Toileting			
Bathing routine			
Feeds self with utensils			
Self feeds using fingers			
Cuts food			
Brushing teeth			
Managing buttons/ snaps			
Managing zippers			

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Sensory Questions:

Does your child appear clumsy, bump into objects or people? Please Specify:

Does your child enjoy the swings and/or slides at the park?:

Does your child seek out increased movement throughout the day (i.e. spinning, running, jumping)? Please Specify:

Does your child have any repetitive behaviors? Please Specify:

Is your child bothered by certain textures (i.e. tags in clothes/certain clothing fabrics, sand, grass)? Please Specify:

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Is your child bothered by loud noises? Please Specify:

Is your child bothered by bright lights? Please Specify:

Is your child bothered by certain movements (i.e. spinning, swinging, car rides)? Please Specify:

Is your child bothered by touch? Please Specify:

Is your child a picky eater? Please Specify:

Is your child bothered by hair brushing/hair cutting/ nail cutting/ teeth brushing/face washing?

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Current Medical History

** Has your child had any earaches/ear infections? YES ☐ NO ☐

Please explain here:

_____

_____

Allergies? (Describe)

_____

_____

Any other serious or recurrent illnesses?

_____

_____

Any operations?

_____

_____

Any accidents?

_____

_____

Any medications? Past: _____

Current: _____

Vision problems? _____

Treatment: _____

Hearing difficulties? _____

Treatment: _____

Dental problems? _____

Treatment: _____

Other Medical Issues:

_____

Developmental History

Age when child: (If you cannot remember specific time, please indicate if it occurred at the expected time or if it was delayed)

Sat up alone: _____ Dressed self: _____

Crawled: _____ Tied shoes: _____

Walked: _____ Fed self independently: _____

Toilet Trained: _____ Weaned from bottle/breast: _____

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Medical History

Please check if your child has had any of the following (and if so, at what age):

Seizures:	_____	Meningitis:	_____
High Fevers:	_____	Encephalitis:	_____
Measles:	_____	Rheumatic Fever:	_____
Mumps:	_____	Tuberculosis:	_____
Chicken Pox:	_____	Sinusitis:	_____
Whooping Cough:	_____	Chronic Colds:	_____
Diphtheria:	_____	Enlarged Glands:	_____
Croup:	_____	Thyroid:	_____
Pneumonia:	_____	Asthma:	_____
Tonsillitis:	_____	Heart Trouble:	_____

Explain any checked items here:

_____

_____

Are immunizations current? ☐ YES ☐ NO