540 President Street | Suite 1E | Brooklyn, NY 11215

Occupational Therapy/Developmental History

IDENTIFYING INFORMATION

Child's name: _____ Age: _____

Sex: ◯ M ◯ F

Address: _____ Birth date:_____

FAMILY INFORMATION

Parent's name: _____

Address: _____

Phone: (H) _____(C) _____

Email: _____

Parent's name: _____

Address: _____

Phone: (H) _____(C) _____

Email: _____

I am concerned about my child's:

☐ Fine Motor Coordination ☐ Sensory Processing ☐ Writing ability

☐ Listening/Attention ☐ Social interaction ☐ Visual Perception

1. Please describe your concern about your child and list strengths and weaknesses:

2. When were the difficulties first noted?

3. Has the problem ◯improved ◯worsened ◯remained the same?
Please explain:

5. Are there situations in which your child has particular difficulty?

◯Yes ◯No If yes, please describe:

4. What motivates your child during play? i.e. StartWars, Nature, Crafts, Sports, Legos, Imaginary Play, Music, etc.:

6. Please describe any current related services that your child receives.

7. Please describe your child's current school placement and services.

8. Do you have any concerns about child's sensory processing (i.e. sensitivity to loud noises, touch, taste, smell, or toe walking?

If so please explain:

9. Is there anything else you feel we should know about your child?

MEDICAL AND DEVELOPMENTAL HISTORY

1. How would you describe your child's health currently?

◯ Excellent ◯ Good ◯ Fair ◯ Poor*

*Explain:

2. Were there any unusual circumstances during the mother's pregnancy or delivery with this child?

◯ Yes ◯ No

If yes, please describe:

3. **At approximately what age did your child do the following:**

_____ sit unassisted _____ walk _____crawl

_____ talk/communicate

4. **Has your child had any ear infections?** ◯Yes ◯No

If yes, # of ear infections _____

were tubes used to drain fluid? ◯Yes ◯No

5. **Has your child had any major illnesses or allergies?** ◯Yes ◯ No

If yes, please describe:

6. **Name and address of pediatrician:**

SOCIAL HISTORY

1. **What opportunities does your child have to play with children of his/her age?**

2. What play activities does your child enjoy?

3. Does she/he play primarily ☐ alone? or ☐ with other children?

4. Does she/he enjoy pretend play? ◯ Yes ◯ No

5. Do you have concerns about your child's behavior? ◯ Yes ◯ No

If yes, please explain: