Therapeutic Designs & Services
Occupational · Speech · Academic · Physical Therapy

Client's Name: _____ Date:_____
Birth Date: _____ Chronological Age: _____
Form complete by: _____

Please check the column that best describes the individual. After each item and category, please write any remarks or comments that you feel may be helpful. Please include the individual's strengths in the comment areas.

Medical Diagnosis (if any): _____
Who Provided the Diagnosis: _____
Age Diagnosis was given:_____

Prenatal History	Yes	No
1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operations or any other difficulties?		
2. Were any drugs or medications taken during pregnancy? Specify:		
3. Were there any major stressful events during pregnancy? (Divorce, illness, death, etc.) Specify.		
4. Were there any abnormal positioning of the umbilical cord during pregnancy? (i.e wrapped around neck, leg, arm etc.) If yes, explain.		
Comments:		

Delivery	Yes	No
1. Was the pregnancy full term? (If no, give the months and weight)		
2. Was it an unusual delivery? (Breech, Caesarian, specify)		
3. Was the labor normal? (If no specify, prolonged, short etc)		
4. Was suction used? (If yes, give details)		
5. Was medication given during delivery? (If yes, specify)		

Comments:

Birth	Yes	No
1. Was the individual considered to be low birth weight? Specify		

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2. Were there any complications such as cyanosis, jaundice, congenital defects, or limpness? Specify.		
3. Was there a need for oxygen, transfusions, or tube feedings? Specify.		
4. Was the individual breast fed? How long?		
5. Was the individual bottle fed?		
6. Did the individual have problems sucking?		
7. Was the length of stay in the hospital unusually long? If yes, specify?		
Comments:		

Infancy	Always	Frequently	Occasionally	Seldom	Never	N/A
a. Cried a lot, fussy irritable						
b. Was good, non-demanding						
c. Was alert						
d. Was quiet						
e. Was passive						
f. Was active						
g. Liked being held						
h. Resisted being held						
i. Was floppy when held						
j. Was tense when held						
k. Had good sleep patterns						
l. Had irregular sleep patterns						

Medical History	Yes	No
1. Has the individual had any of the following? Please give dates and indicated if the individual had the illness or was immunized.		
a. Meningitis		
b. Measles		
c. Chicken Pox		
d. High Fevers		
e. Mumps		
f. Whooping Cough		
g. Scarlet Fever		
h. Convulsions		
i. Diabetes		
j. Lung or Bronchial Difficulties		
k. Heart Trouble		
l. Seizures (indicate when and how often)		

m. Allergies		
n. Excessive Vomiting		
o. Tuberculosis		
p. Herpes		
2. Has the individual had any physical injuries or surgical procedures? If yes, describe please.		
3. Has there been an eye evaluation? Is there a diagnosed visual problem? a. Date: b. Diagnosis: c. Glasses?		
4. Does the individual have a hearing problem? If yes, specify.		
5. Has the individual received Auditory Integration Training or Sound Therapy?		
6. Is the individual currently on medications? If yes, specify. Medication Dosage (mg& times/day) Purpose		
Comments:		

Developmental History	Yes	No
1. At what age did the individual? (Please specify ages as near as possible.)		
a. Roll over both ways intentionally?		
b. Belly crawl?		
c. Crawled on all fours (creep)?		
d. Sit alone?		
e. Walk while holding on?		
f. Speak his/her first word? (What was it?)		
g. Speak his/her first sentence? (What was it?)		
h. Drink from a cup independently?		
i. First clapped his/her hands?		
j. Use a spoon independently?		
k. Feed him/herself independently?		
l. Undress him/herself independently?		
m. Dress him/herself independently?		
n. Button independently?		
o. Toilet trained?		
p. Started pre-school?		
q. Tied his/her own shoes?		

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Individual Presently	Always	Frequently	Occasionally	Seldom	Never	N/A
1. Is mostly quietly						
2. Is overly active						
3. Tires easily						
4. Talks constantly						
5. Too impulsive						
6. Is restless						
7. Is stubborn or resistant to change						
8. Overreacts or exhibits frequent temper tantrums						
9. Is clumsy or falls often						
10. Has difficulty separating from primary caretakers						
11. Has nervous habits or tics						
12. Wets bed						
13. Has poor attention span						
14. Is frustrated easily						
15. Has unusual fears						
16. Rocks self-frequently						
17. Has difficulty learning new tasks (i.e. writing, throwing a ball, riding a bike, work tasks, chores)						

Comments:

Sensorimotor History

For Infants and Toddlers

Check areas of difficulty; underline specific problems, check prominent difficulties. If the child has overall difficulty in one category, or shows several items in three or more categories, this may indicate a need for an occupational therapy evaluation.

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Does your child exhibit the following behaviors?

Dressing, Bathing, Touch:	**Yes frequently:**	**Sometimes or never:**	**Comments**
1. Doesn't want to wear clothing (with young infant, most content when in diaper or naked).			
2. Prefers certain clothing, complains that garments are too tight or itchy (infants over 15 months).			
3. Distressed by having hair or face washed.			
4. Distressed when clothes are removed.			
5. Resists cuddling, pulls away, or arches.			
6. Doesn't notice pain when falling, bumping, or when the doctor gives shots.			
Movement	**Yes frequently:**	**Sometimes or never:**	**Comments:**
1. In constant motion, rocking, running about, unable to sit still for an activity.			
2. Never crawled before starting to walk (for infants over 1 year).			
3. Fear of being swung in air, swings, or merry-go rounds.			
4. Craves swinging and moving upside down.			
5. Is clumsy, falls, has poor balance, bumps into things (infants over 1 year).			
Listening, Language, and Sound:	**Yes frequently:**	**Sometimes or never:**	**Comments:**
1. Startled or distress by loud sounds. i.e. vacuum, door bell, or barking dog			
2. Doesn't respond to verbal cues (hearing not a problem, for infant over 1 year).			

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3. None or very little vocalizing or babbling.			
4. Distracted by sounds not normally noticed by average person.			
Looking and Sight:	**Yes frequently:**	**Sometimes or never:**	**Comments:**
1. Sensitive to bright lights, cries, or closes eyes.			
2. Avoids eye contact, turns away from the human face.			
3. Becomes overly excited in crowded, bustling settings such as a crowded supermarket, restaurant (for infants over 1 year).			
Play Abilities:	**Yes frequently:**	**Sometimes or never:**	**Comments:**
1. Does not show ability for imitative play (for infants over 10 months).			
2. Wanders around aimlessly without focused exploration or purposeful play (for infants over 15 months)			
3. Easily breaks toys and other things destructively (for infants over 15 months)			
4. Needs total control of the environment, runs the show.			
Emotional Attachment/Emotional Functioning:	**Yes frequently:**	**Sometimes or never:**	**Comments:**
1. Prefers to play more with objects and toys than with people.			
2. Does not interact reciprocally (back and forth exchanges with caregiver)			
3. Self abusive			
4. Everyone has difficulty understanding the child's cues or emotions:			
Self Regulation	**Yes frequently:**	**Sometimes or never:**	**Comments:**
1. Irritable, fussy.			
2. Can't calm self effectively by sucking on pacifier, looking at toys,			

or listening to caregiver (for infants 10 months or older).			
3. Can't change from one activity to another without distress.			
4. Must be prepared in advance several times before change is introduced.			
Attention	**Yes frequently:**	**Sometimes or never:**	**Comments:**
1. Easily distractible, fleeting attention.			
2. Too distracted to stay seated for meals.			
Eating, Sleeping:			
1. Requires extensive help to fall asleep. Specify: rocking, long walks, stroking hair or back, car ride, etc.			
2. Eats only soft food (for children over 9 months).			
3. Excessive drooling beyond teething stage.			

How concerned are you about the above checked problems?

Not concerned Slightly Moderately Very

Questions/Comments: