FAULKNER UNIVERSITY
CENTER FOR THERAPY AND RESEARCH

Department of Occupational Therapy
Faulkner Center for Therapy and Research
Pediatric Case History

Please complete the form to the best of your ability and return it prior to your evaluation appointment. We will review this form with you and help you complete it during our visit with your child.

(Please include copies of related evaluations and/or current IEP's)

Today's Date_____

Child's Name _____Sex____ Age_____

Birth date_____

Mother's (or guardian's) Name_____ Phone#_____

Father's (or guardian's) Name_____ Phone#_____

Home Address_____

Who has custody of this child?_____

Who is filling out this questionnaire? Relationship to child_____

_____

EXPLANATION OF CONCERNS

Describe your concerns regarding your child's Gross Motor Skills (balance, coordination), Fine Motor Skills (handwriting, using tools/manipulatives), Behavior, Development, or Self Care Skills (bathing, dressing, grooming, etc.) :

_____

_____

When did you first notice the issue(s)?_____

_____

Do you feel that your child's ability to participate in/successfully complete daily tasks is different than children his or her own age?

(Circle One) Yes No

Describe: _____

_____

Who have you seen regarding these issues? (i.e., Doctor's, Psychologist, etc.,

Include name, address and telephone number)_____

_____

_____

Has your child ever received an occupational therapy evaluation? (Circle One) Yes No

By whom?_____

When?_____

How has this issue changed since you first noticed it?_____

What has been tried to help with the issue? _____

What has helped/not helped the issue?_____

How does the issue affect your child or family?_____

_____

FAMILY INFORMATION

Language(s) spoken in the home_____

Father's occupation_____Employer_____

Mother's occupation_____Employer_____

Level of Education:

Father _____

Mother_____

Siblings: Names & Ages:

_____

_____

_____

_____

_____

Are there any family members or relatives who have or had received any kind of Special Education Services and/or therapy services ? (Circle One) Yes No

Describe:_____

_____

Are there any family or social stressors that could be affecting the child? (For example: divorce, death, military, relocation)

(Circle One) Yes No

Describe:_____

_____

MEDICAL HISTORY

Is this your biological child? Yes No

If not, can you provide information about the child's biological parents?_____

_____

During pregnancy with this child, did the mother have any illnesses? Yes No

If so, what?_____

_____

During pregnancy with this child, did the mother take any medications? Yes No

If so, list:_____

_____

During pregnancy with this child, did the mother use drugs or alcohol? Yes No

If so, list:_____

_____

Was your child born full-term? Yes No

If not, when was he/she born? _____

Was labor at all problematic? Yes No

If so, explain:_____

Was the child's birth at all problematic? Yes No

If so, explain:_____

Type of Delivery: (Circle One) Vaginal Cesarean

Did your child have any trouble breathing after birth? Yes No

Was the child kept in an incubator? Yes No

If so, explain_____

_____

Was feeding a problem? Yes No

If so explain:_____

_____

Were there any other problems after birth? Yes No

If so, explain:_____

Has your child ever been hospitalized? Yes No

Age and reason:_____

_____

Has your child ever had any serious illnesses or accidents? Yes No

Explain:_____

_____

Has your child ever fainted? Yes No

If so, explain:_____

_____

Has your child ever had seizures? Yes No

Describe:_____

_____

Does your child have problems hearing? Yes No

Has your child had ear Infections? Yes No

If so, how many? _____

_____

Last hearing exam date and results:_____

_____

Has your child had middle ear tubes inserted? Yes No

If so, when?_____

Did your child have his/her tonsils/adenoids removed? Yes No

If so, when?:_____

Does your child have any problems seeing? Yes No

Wear glasses? Yes No

Does your child have any trouble sleeping at night? Yes No

Waking up in the morning? Yes No

Explain:_____

_____

Does your child have allergies or asthma? Yes No

If so, list:_____

_____

_____

List all current medications your child takes:

_____

_____

_____

_____

Pediatrician's name, address, and telephone number: _____

Please list other professionals your child sees:

ENT_____

Psychologist_____

Therapist_____

Neurologist_____

Physical Therapist_____

Occupational Therapist_____

Other specialists_____

_____

Describe any other medical history: _____

_____

_____

DEVELOPMENTAL HISTORY

Feeding Development

Bottle fed? Yes No Breast fed? Yes No

Age weaned from bottle? _____ Age weaned from breast?_____

Skill	Age
Drink from an open cup	_____
Drink from a straw	_____
Eat with fingers	_____
Eat with spoon	_____
Eat with fork	_____

Does your child have any feeding or swallowing problems now? Yes No

Describe:_____

_____

Is he/she a picky eater? Yes No

If yes, please explain_____

_____

List some foods your child eats in each category:

Pureed foods_____

Dry crunchy foods_____

Wet chewy foods_____

Gummy/sticky foods_____

Developmental Milestones

Skill	Age
Sit alone	_____
Crawl	_____
Pull up	_____
Stand	_____
Walk	_____
Run	_____
Jump	_____
Dress self	_____
Throw a ball	_____
Toilet trained	_____

Self Care Skills

Place a checkmark by each of the following skills that your child can complete independently:

__ put on socks
__ take off socks
__ put on shoes
__ take off shoes
__ untie shoes
__ tie shoes
__ put on underwear
__ take off underwear
__ put on pants
__ take off pants
__ put on shirt
__ take off shirt
__ put on jacket
__ take off jacket
__ buttons
__ zippers
__ snaps
__ bathe body
__ wash hair
__ wash face
__ brush teeth
__ brush hair
__ style hair as preferred
__ wash hands
__ cut finger/toenails
__ potty training:
day: bladder __ bowel __
night: bladder __ bowel __
__ (if applicable) shaves face
__ (if applicable) shaves legs
__ (if applicable) shave armpits
__ (if applicable) manages feminine hygiene

Does your child have an established hand dominance? Yes No

If yes, circle one: Left Right

Does your child wet the bed? Yes No

How often?_____

_____

If your child has difficulties with any of the above or any other motor activities, please explain:_____

_____

Describe any concerns you have with your child's physical development:_____

_____

_____

_____

Behavior

Does your child have meltdowns/tantrums (circle one):

Rarely Sometimes Frequently

What typically triggers your child's meltdowns/tantrums?

_____

_____

What is most effective in calming your child down after a meltdown/tantrum?

_____

_____

Screentime

Approximately how much screen-time (hours/minutes) does your child have per day?

_____

Reading and Writing (if age appropriate please complete)

Describe any problems your child has had with

Reading:_____

Writing:_____

How often do you read to your child?_____

List some of your child's favorite books:_____

_____

Math

Describe any problems your child has had with learning math:_____

_____

Cognitive Development

Which toys did your child play with at:

1 year _____

2 years _____

3 years _____

4 years _____

5 years _____

Current age _____

Does your child seem to learn:

Quickly? □ Slowly? □ Average? □

How would you describe your child's learning style?_____

_____

How does your child solve everyday problems?_____

_____

Provide an example if possible:_____

_____

How does your child show reasoning skills? _____

_____

How does your child do when trying to follow multi-step directions?_____

_____

_____

_____

EDUCATIONAL HISTORY

Where does your child attend school?_____

What grade does your child attend?_____

_____

List any concerns you noticed your child having at school:_____

_____

List any concerns the child's teacher has expressed:_____

_____

What has the school tried to address these concerns?_____

_____

How does your child make and interact with friends?_____

_____

What are your child's strengths?_____

_____

What does your child enjoy? _____

_____

Provide any other information you would like for us to know_____

_____

_____

_____

_____