Confidential Personal History for Children

Today's Date	Completed By
Child's First Name	Child's Last Name
Birthdate	Age
Gender	Pronouns

Address

Are you Aboriginal or Torres Strait Islander?
☐ Yes Aboriginal
☐ Yes Torres Strait Islander
☐ No - Neither

If Yes: Nation/Country

Contact Information

Caregiver A's Name	Caregiver B's Name
Address:	Address:
Home phone:	Home phone:
Mobile phone:	Mobile phone:
Emergency Contact:	
Phone	Relationship
School	Year Group
Teacher's Name	Type of Classroom e.g. composite class, single, specialised

Child's GP & Allied Health Providers

Name	Profession	Phone
Email		
Name	Profession	Phone
Email		
Name	Profession	Phone
Email		

Are there any medical precautions the therapist should be aware of when working with your child?

☐ Yes ☐ No
Please detail:

____

____

Family Profile

	Date of Birth/Age	Gender	Occupation e.g. student, farmer etc	Biological Relation?
Caregiver A		Choose an item.		☐Yes ☐No
Caregiver B		Choose an item.		☐Yes ☐No
Sibling/s		Choose an item.		☐Yes ☐No
Sibling/s		Choose an item.		☐Yes ☐No
Sibling/s		Choose an item.		☐Yes ☐No
Sibling/s		Choose an item.		☐Yes ☐No
Sibling/s		Choose an item.		☐Yes ☐No

Who is living at home?

Marital Status of Caregivers:

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Other

Mother's Education		Father's Education	
Less than High School	☐	Less than High School	☐
High School	☐	High School	☐
University	☐	University	☐
Post Graduate	☐	Post Graduate	☐

Has there been any specific events or traumas linked with the onset of your child's difficulties?

- ☐ Yes
- ☐ No

Please describe:

What, if any, stresses are affecting your family at this time?

____

____

____

What language/s do you speak at home?

____

____

____

Personality Profile

What are your child's gifts/strengths?

____

____

____

____

What do you enjoy most about your child and family?

____

____

____

What are the presenting problems/difficulties for your child? (All categories below may not apply)

Academic:
Activities of daily life (e.g. eating, dressing)
Relationships/Social:
Cognition:

Sensory:
Fine Motor:
Gross Motor:
Play:
Other:

What kind of interests and/or activities does your child have?
(Hobbies, sports, clubs) Please list them in order of preference beginning with the favourite activity.

____

____

____

____

____

____

____

Has your child been diagnosed with any of the following (PLEASE CHECK ALL THAT APPLY):

☐	ASD	Level
☐	ADHD	Detail Type
☐	Cerebral Palsy	Detail
☐	Spina Bifida	Detail
☐	Intellectual Delay	
☐	Neurological Condition/s	Detail
☐	Muscular Conditions	Detail
☐	Anxiety Disorder	Detail
☐	Mood Disorder	Detail
☐	Hypermobility	
☐	Brain Injury	
☐	Down Syndrome	
☐	Dyslexia	
☐	Fragile X Syndrome	
☐	Learning Disabilities (Specify if possible):	Detail
☐	Sensory Processing Disorder	
☐	Tourette's Syndrome	
☐	Other (specify):	

Medications

Please list any medications or supplments that your child currently takes

Medication: Purpose: When taken:

Medication: Purpose: When taken:

Medication: Purpose: When taken:

Medication: Purpose: When taken:

Medication: Purpose: When taken:

Family Adaption

How would you describe your child's general adjustment at home?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent

How does your child get along with each member of the family?

Have there been any traumatic family events in the course of this child's development? Please comment if you feel comfortable doing so.

Pregnancy

(If child is adopted or in foster care answer with best knowledge else, please skip to next section)

		Comments
Was it planned?	☐ Yes ☐ No	
Were there complications?	☐ Yes ☐ No	
Any health problems? Please specify	☐ Yes ☐ No	
Confinement to bed?	☐ Yes ☐ No	
Was mother exposed to harmful substances?	☐ Yes ☐ No	
Did mother smoke?	☐ Yes ☐ No	
Did mother consume alcohol?	☐ Yes ☐ No	
Did mother take any medications? Please specify	☐ Yes ☐ No	
Was mother physically active?	☐ Yes ☐ No	
Were there any previous pregnancy complications?	☐ Yes ☐ No	

Any other comments you wish to make about your pregnancy?

____

____

____

____

Labour & Delivery

Describe your experience during labour and delivery:		
		Comments/Information
Length of Labour?		
Premature?	Yes ☐ No ☐	
Forceps Delivery?	Yes ☐ No ☐	
Suction?	Yes ☐ No ☐	
Delivery Position e.g. Breech?		
Caesarean Birth? (reason)	Yes ☐ No ☐	
Birth Weight?		
APGAR Ratings? (if known)		
Cried Immediately?	Yes ☐ No ☐	
Required Specialist treatment e.g. oxygen, jaundice etc?	Yes ☐ No ☐	
Birth Injuries	Yes ☐ No ☐	
Immediate Physical Contact with Mother?	Yes ☐ No ☐	
Positive Bonding experience between mother and newborn at birth	Yes ☐ No ☐	
Describe any separations from mother during first days of life		
Did mother experience any post-partum depression?	Yes ☐ No ☐	

Infancy & Toddlerhood

Going back to the first two years of the child's life, answer the following questions

	Yes	No	Comments
Breastfed	☐	☐	
Extended separations during first two years (over 3 days)	☐	☐	
Specific health problems during this period	☐	☐	
Thumb sucking/ dummy (until what age)	☐	☐	
Feeding problems	☐	☐	
Sleeping problems	☐	☐	
Colic or "Fussy baby"	☐	☐	
Prefer certain positions as an infant (describe)	☐	☐	
Dislike lying on stomach	☐	☐	
Dislike lying on back	☐	☐	
Able to self soothe	☐	☐	
On a regular schedule	☐	☐	
Enjoy bouncing	☐	☐	
Become calmed by car rides or infant swings	☐	☐	
Become nauseated by car rides or infant swings	☐	☐	
Toe walker (until what age)	☐	☐	
Go through "terrible twos"	☐	☐	
Describe their first two years of life in your own words:			

Childhood illness/problems

Conditions	None	Couple	Many	Age	Comments
Ear Infections	☐	☐	☐		
Grommets	☐	☐	☐		
Respiratory Issues	☐	☐	☐		
High Fevers	☐	☐	☐		
Meningitis	☐	☐	☐		
Adenoid Problems	☐	☐	☐		
Frequent Colds	☐	☐	☐		
Strep Throat	☐	☐	☐		
Allergies	☐	☐	☐		
Asthma	☐	☐	☐		
Bronchitis	☐	☐	☐		
Skin Problems	☐	☐	☐		
Gastro- Intestinal problems	☐	☐	☐		
Seizures	☐	☐	☐		
Epilepsy	☐	☐	☐		
Nightmares	☐	☐	☐		
Sleep	☐	☐	☐		
Bedwetting	☐	☐	☐		
Nail Biting	☐	☐	☐		
Broken limbs	☐	☐	☐		
Other					

Has your child ever been hospitalized?

☐ Yes

☐ No

If Yes, please describe why they were hospitalized

____

____

____

Developmental Milestones

(Give approximate age if remembered, or comment on anything unusual)

Milestone	Age Acheived
Rolling Over	
Crawling Brief? Yes ☐ No ☐	
Walking	
Sitting Unassisted	
Saying single words	
Speaking in sentence	
Chewing solid food	
Drink unassisted from a cup	
Using cutlery	

Please describe their crawling phase e.g. commando, typical, bum shuffle

Visual Development

Has your child experienced any problems with their eyesight or vision?	☐ Yes ☐ No If Yes please explain:
Are there any current problems of which you are aware?	☐ Yes ☐ No If Yes please explain:
When was the last time their eyesight was tested?	

Auditory Development

Are there any current hearing problems of which you are aware?	☐ Yes ☐ No If Yes please explain:
When was the last time their hearing was tested?	

Speech & Language Development

How would you describe your child's speech and language development?

☐ Normal

☐ Delayed

☐ Advanced

Did your child begin speaking in single words, then two, then a sentence?

☐ Yes

☐ No

Did your child not talk for a long while, and then all of a sudden speak in complete sentences?

☐ Yes

☐ No

Do you or others have difficulty understanding what your child says?

☐ Yes

☐ No

First Words and what age?

____

____

____

Describe any speech related problems:

____

____

____

Sensory & Motor Development

Please check any that apply:

Auditory	☐ My child seems to be overly sensitive ☐ My child doesn't seem to react ☐ My child actively seeks out
Tactile	☐ My child seems to be overly sensitive ☐ My child doesn't seem to react ☐ My child actively seeks out
Visual	☐ My child seems to be overly sensitive ☐ My child doesn't seem to react ☐ My child actively seeks out
Movement	☐ My child seems to be overly sensitive ☐ My child doesn't seem to react ☐ My child actively seeks out
Taste	☐ My child seems to be overly sensitive ☐ My child doesn't seem to react ☐ My child actively seeks out
Smell	☐ My child seems to be overly sensitive ☐ My child doesn't seem to react ☐ My child actively seeks out

- ☐ My child has difficulty differentiating sensory experiences e.g., confuses sounds, can't find objects in drawer or bag without looking, bumps into things, trips over things
- ☐ My child has trouble learning new movements
- ☐ My child tends to be clumsy and has balance or coordination difficulties

Please describe any sensory concerns you have or have noticed.

Previous Testing & Treatment

Has your child had any previous ASSESSMENTS or TREATMENT?

Please attach relevant reports

- ☐ Medical
- ☐ Audiological (hearing)
- ☐ Speech
- ☐ Educational
- ☐ Psychological
- ☐ Physiotherapy
- ☐ Occ. Therapy
- ☐ Other

Please describe

____

____

____

	Assessment			Treatment		
	Yes	No	Place/Date	Yes	No	Place/Date
Medical	☐	☐		☐	☐	
Audiological	☐	☐		☐	☐	
Speech	☐	☐		☐	☐	
Physiotherapy	☐	☐		☐	☐	
Educational	☐	☐		☐	☐	
Psychological	☐	☐		☐	☐	
Occ. Therapy	☐	☐		☐	☐	
Other	☐	☐		☐	☐	

Education

How did your child adapt to the first day(s) at school or pre-school?

- ☐ Mostly Positive
- ☐ Mixed
- ☐ Mostly Negative

How old where they when they started pre-school?	
How many days did they attend per week?	
How old where they when they started primary school?	

In general, how would you describe your child's experience/learning at school from commencement to the present time?

Please provide us with more detailed information about your child's schooling experiences encountered (positive and negative). *Please include any school changes*

Pre-school/Day care	
Early Stage 1 (Kindergarten)	
Stage 1 (Year 1 – 2)	
Stage 2 (Year 3 – 4)	
Stage 3 (Year 5 – 6)	
Stage 4 (Year 7 – 8)	
Stage 5 (Year 9 – 10)	
Stage 5 (Year 11 – 12)	

Goals

What are your goals for your child's occupational therapy? Please be as specific as possible.

1	
2	
3	
4	
5	
6	
7	
8	

Allied Health Assistants

At Light Up Their World we have one occupational therapist, this can mean a significant delay in services due to high demand. While we are endeavoring to hire more OT's, there is a national shortage.

To reduce the delay within our practice we employ Allied Health Assistants (AHA).

Some Caregivers are concerned that their child won't get the same level of support with an AHA. Please be assured the occupational therapist, as an Allied Health Professional (AHP), has responsibility for supervising an AHA who is assisting with occupational therapy interventions. The occupational therapist:

- ✓ remains responsible for patient assessment and overall care and treatment plans
- ✓ maintains a clear understanding of the AHA's role (as detailed in the AHA's position description)
- ✓ has a good understanding of the AHA's knowledge and skill level
- ✓ analyses clinical practice to identify tasks that do not require clinical judgement, professional assessment, or care planning or evaluation, and that could be completed by an appropriately trained and supported AHA
- ✓ provides support to the AHA in undertaking their role. This may include demonstrating how to perform specific tasks associated with their role, or providing opportunities to access training and professional development to enable skill acquisition
- ✓ delegates tasks appropriately and provides appropriate levels of supervision to support the AHA.

See the task delegation on the next page for a breakdown.

Therefore, your child will continue to get a high standard of support and therapy through an AHA. We ask you consider this as an option for therapies to reduce workload on the OT, increase your access to therapies and ensure you get support quicker.

☐ I am happy for my child to access therapies through an Allied Health Assistant if the Occupational Therapist deems it appropriate.

Thank you for your time to fill this in. Please return this document to admin@lightuptheirworld.com.au

Task/Activity List for AHA Scope of Practice

from NSW Health Allied Health Assistant Framework

Delegated Patient Care – general options for AHAs

- ✓ Prepare patients/clients for treatment
- ✓ Assist in patient/client treatment, therapeutic activities, retraining programs according to the specific care plan that has been prescribed by an AHP, being aware of background diagnosis and precautions
- ✓ Assist with routine evaluations by AHP, collect observational data as required, and report any changes in patient/client behaviour or performance
- ✓ Supervise activities and exercises of patients/clients individually or in groups under direction of the AHP
- ✓ Check posture and positioning and report on performance, problems or need for change
- ✓ Provide assistance in therapy where two or more people are required for safety; assist with patient/client positioning/manual handling
- ✓ Report any change in behaviour or performance of patients/clients
- ✓ Assist with the organisation of groups, prepare, and conduct or co-facilitate group activities
- ✓ Act as escort to patients/clients requiring supervision/assistance in the healthcare facility environment or on home visits
- ✓ Document in patient/client medical record as appropriate to role.

Clinical Support – general options for AHAs

- ✓ Assist with patient/client intake – collect referrals, enter data
- ✓ Prepare treatment space/room for next patient/client
- ✓ Prepare or make aids/devices for therapy under the supervision of the AHP
- ✓ Update/maintain resources
- ✓ Participate in quality activities, assist with the compilation and/or evaluation of data on projects, satisfaction surveys, etc.
- ✓ Maintain learning, for example, participation in education, orientation, and mandatory training programs
- ✓ Assist with cleaning of therapy aids and equipment; ensure all equipment is safe and functional
- ✓ Assist with administration of equipment loan pool and other services as deemed necessary by the manager
- ✓ Deliver equipment and adjust in home according to specifications from AHP
- ✓ Assist in development of patient/client handouts/developing resources for community education
- ✓ Participate in supervision processes.