Kinetic Kids Occupational Therapy, PLLC
312 E 85th Street BA
New York, NY 10028
T (917) 282-6527
kinetickidsot@gmail.com
www.kinetickidsot.com

CONFIDENTIAL PERSONAL HISTORY FOR CHILDREN AND YOUNG ADULTS

Today's Date: _____ Completed by: _____
Child's Last Name: _____ Child's First Name: _____
Address: _____ City, State, Zip: _____
Date of Birth: _____ Age: _____ Gender: _____
Ethnicity: _____

CONTACT INFORMATION

Parent's Name: _____ Relationship: _____
Cell phone: _____ E-mail address: _____

Parent's Name: _____ Relationship: _____
Cell phone: _____ E-mail address: _____

EMERGENCY CONTACT

Name: _____ Relationship to child: _____
Phone Number: _____ Alternate phone number: _____

SCHOOL INFORMATION

Name of School:_____ Grade in School: _____

CHILD'S PRIMARY CARE PHYSICIAN

Name: _____ Profession: _____ Phone: _____
Address: _____
Are there any medical precautions the therapist should be aware of when working with your child?
_____
_____

FAMILY MEMBERS – Detailed Information

Parent 1: Age ____ Sex ___ Adopted: Yes ___ No ___ Handedness: R ___ L ___ Occupation _____

Parent 2 Age ____ Sex ___ Adopted: Yes ___ No ___ Handedness: R ___ L ___ Occupation _____

Do you have any other children?_____

Marital Status of Parents: Married ____ Separated ____ Divorced ____ Other _____

Parent 1's Education

Less than High School _____ High School/GED _____ College _____ Post College (grad school) _____

Parent 2's Education

Less than High School _____ High School/GD _____ College _____ Post College (grad school) _____

PERSONALITY PROFILE

What are your current concerns about your child? Please be detailed.

1._____

2._____

3._____

4._____

5._____

6._____

What are your child's gifts / strengths? _____

_____

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

Academic: _____

_____

Activities of daily life (e.g., eating, dressing): _____

_____

Relationships: _____

_____

Sensory: _____

_____

Motor: _____

_____

Play: _____

_____

Other: _____

_____

What kind of interests and activities does your child have (i.e., hobbies, sports, clubs)? Please list them in order of preference beginning with the favorite activity.

_____

_____

_____

Has your child been diagnosed with anything? Please list all diagnoses.

_____

Is there family history of ASD, SPD, ADHD, mental health difficulties, or neurological diagnoses?

_____

Please note who provided your child's diagnosis and based on what criteria (i.e., test scores, comp rehensive clinical evaluation, genetic study, etc.): _____

_____

MEDICATIONS List any medications your child is **currently** taking, its purpose, and frequency of dosage:

_____

FAMILY ADAPTATION

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?

Father _____

Mother _____

Siblings _____

Have there been any traumatic family events in the course of this child's development? Yes _____ No _____

Please comment _____

Have there been any major moves (i.e., city to city, country to country)? Yes _____ No _____

Please comment _____

PREGNANCY

What kind of experience was the pregnancy for both mother and father?

Mother _____

Father_____

Was it planned? Yes _____ No _____ Comments _____

Were there complications? Yes _____ No _____ Comments _____

Was this an IVF pregnancy ? Yes _____ No _____ Comments _____

Severe stress? Yes _____ No _____ Comments _____

Health problems? Yes _____ No _____ Specify _____

Confinement to bed? Yes _____ No _____ Comments _____

Did mother consume alcohol? Yes _____ No _____ Comments _____

Did mother take any medication? Yes _____ No _____ Specify _____

Was mother physically active? Yes _____ No _____ Comment _____

Were any previous pregnancies complicated? Yes _____ No _____ Comments _____

Other _____

LABOR AND DELIVERY

Describe your experience during labor and delivery _____

_____

Length of labor? _____

Premature? Yes _____ No _____ Specify _____

Forceps used? Yes _____ No _____

Suction? Yes _____ No _____

Delivery position (i.e., breech)? _____

Caesarean birth? Yes____ No____ Reason _____

Birth weight? _____ lbs _____ oz

APGAR ratings (if known) _____

Cried immediately? Yes _____ No _____

Required special treatment (i.e. required oxygen, jaundice, etc.)? Yes _____ No _____ Specify _____

Birth injuries? Yes _____ No _____ Specify _____

Did the newborn have immediate physical contact with the mother? Yes _____ No _____

Was there a 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 when your child was an infant what type of baby was he/she (i.e feeding, sleeping, activity level)? _____

_____

_____

Breastfed? Yes _____ No _____ Comments _____

Extended separations during first two years (over 3 days)? Yes _____ No _____ Comments _____

Specific health problems during this period? Yes _____ No _____ Comments _____

Thumb sucking / pacifier (until what age)? Yes _____ No _____ Comments _____

Feeding problems? Yes _____ No _____ Comments _____

Sleeping problems? Yes _____ No _____ Comments _____

Colic or “fussy baby”? Yes _____ No _____ Comments _____

Prefer certain positions as an infant? Yes _____ No _____ Specify _____

Dislike lying on stomach? Yes _____ No _____ Comments _____

Dislike lying on back? Yes _____ No _____ Comments _____

Able to self soothe? Yes _____ No _____ Comments _____

On a regular schedule? Yes _____ No _____ Comments _____

Enjoy bouncing? Yes _____ No _____ Comments _____

Became calm by car rides or infant swings? Yes _____ No _____ Comments _____

Become nauseated by car rides or infant swings? Yes _____ No _____ Comments _____

Toe walker? Yes _____ No _____ Until what age? _____

Go through “terrible twos”? Yes _____ No _____ Comments _____

Describe your child’s toddler stage: _____

CHILDHOOD ILLNESSES / PROBLEMS

Check all the items below that apply:

Ear infections? None _____ A couple _____ Many _____ Age/Comments/Deficits _____

Tubes in ears? Yes _____ No _____ Age/Comments/Deficits _____

Respiratory problems? Yes _____ No _____ Age/Comments/Deficits _____

High fever? Yes _____ No _____ Age/Comments/Deficits _____

Meningitis? Yes _____ No _____ Age/Comments/Deficits _____

Adenoid problems? Yes _____ No _____ Age/Deficits/Comments _____

Frequent colds? Yes _____ No _____ Age/Deficits/Comments _____

Strep throat? Yes _____ No _____ Age/Deficits/Comments _____

Allergies? Yes _____ No _____ Specify _____

Check all the items below which have been a problem and provide details:

Asthma _____ Describe _____

Bronchitis _____ Describe _____

Skin problems _____ Describe _____

Gastro-Intestinal problems _____ Describe _____

Seizures _____ Describe _____

Epilepsy _____ Describe _____

Nightmares _____ Describe _____

Bedwetting _____ Describe _____

Nail Biting _____ Describe _____

Broken limbs _____ Describe _____

Other(s) _____ Describe _____

Has he/she ever been hospitalized? Yes _____ No _____

If yes, list reasons:_____

_____

Has he/she ever had a serious accident/injury? Yes _____ No _____

If yes, list accidents:_____

_____

Are there any other medical illnesses or conditions which have been diagnosed?

_____

_____

Is your child in good general health at the present time? Yes _____ No _____

If no, please describe _____

DEVELOPMENTAL MILESTONES

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

Rolling over _____ Walk _____ Say words _____

Sit alone _____ Chew solid food _____ Say sentences _____

Crawl _____ Was crawling a typical pattern? Yes _____ No _____

Drink from a cup _____

Was crawling phase brief? Yes _____ No _____ Absent? Yes _____ No _____

Experience hesitancy or delays in learning to go down stairs? Yes _____ No _____

VISUAL DEVELOPMENT

Has your child experienced any problems with his/her eyesight or vision? _____

_____

Are there any current problems of which you are aware?_____

_____

When was the last time his/her eyesight was tested?_____

_____

AUDITORY DEVELOPMENT

Has your child experienced any problems with his/her hearing (i.e., operations, infections, tubes)?

_____

_____

Ear infections? Seldom _____ Sometimes _____ Often _____

Mild _____ Moderate _____ Severe _____

Are there any current hearing problems of which you are aware?

_____

_____

SPEECH AND 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, then all of a sudden speak in complete sentences? Yes _____ No _____

Do you or others have difficulty understanding what child says? Yes _____ No _____

First words and at what age: _____

Describe any speech related problems: _____

_____

SENSORY & MOTOR DEVELOPMENT

My child seems to be overly sensitive to sensory experiences more so than most people. Yes _____ No _____

Auditory _____ Tactile _____ Visual _____ Movement _____ Taste _____ Smell _____

My child doesn't seem to react to sensory experiences as readily as most people. Yes _____ No _____

Auditory _____ Tactile _____ Visual _____ Movement _____ Taste _____ Smell _____

My child actively seeks out sensory experiences more so than most people. Yes _____ No _____

Auditory _____ Tactile _____ Visual _____ Movement _____ Taste _____ Smell _____

My child has difficulty differentiating sensory experiences (i.e., confuse sounds, can't find objects in drawer or bag without looking, bumps into things). Yes _____ No _____ Describe _____

_____

My child has trouble learning new movements. Yes _____ No _____

My child tends to be clumsy and has balance and coordination problems. Yes _____ No _____

PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENT?

_____

_____

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

_____

_____

Is your marital situation stable and positive at this time? Yes _____ No _____ Comment _____

_____

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

_____

_____

Which language(s) is spoken at home?_____

Are there other individuals or family members living at home (other than immediate family)?

_____

EDUCATION

Where does your child currently attend school?_____

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

Mostly positive_____ Mixed _____ Mostly negative _____

How old was he/she? _____ How much time did he/she attend per week? _____

In general, how would you describe your child's experience/learning at school from kindergarten to the p resent time? _____

_____

Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment _____

_____

Pre-school/Daycare _____

_____

Primary (K-3rd Grade) _____

_____

Junior (4th-6th Grade) _____

_____

Has there been remedial help given **inside** the school system? Yes _____ No _____

If yes, describe:_____

_____

SLEEPING- Does your child currently have any sleeping difficulties? Yes____ No____

What time does your child awaken? _____

What mood is your child in upon morning waking? _____

What time is your child put to bed? _____

What time does your child fall asleep? _____

Where does your child sleep? _____

Does your child have difficulty with sleeping? Yes _____ No _____

If yes, do family members have interrupted sleep, as a result? Yes _____ No _____

How many times per night does he/she wake? Almost never _____ 1-2 _____ 3-4 _____ 5-6 _____ 7+ _____

What does your child do when he/she awakens?

Whimper _____ Screams _____ Play with toys _____ Goes to parent bedroom _____

Puts self-back to sleep _____ Other (specify) _____

What activities do you use to get your child back to sleep? (check all that apply)

Feeding _____ Singing _____ Humming _____ Holding _____ Rocking _____ Bouncing _____

Massage _____ Other (specify) _____

How old was your child when he/she consistently slept through the night? _____

Does your child seem to require too much or too little sleep or at odd times? Yes _____ No _____

How many hours nightly? _____ What times of day? _____

Does your child take naps? Yes _____ No _____

Frequency of naps? _____ Duration of naps? _____ Location of naps? _____

Does child need help to fall asleep for nap? Yes _____ No _____

What activities do you use as part of your child's bedtime routine? (check all that apply)

Bath time _____ Singing/Humming _____ Reading _____ Holding _____ Bouncing _____

Massage _____ Rocking _____ Other(s) _____

Please describe any necessary specifics regarding bedtime routine: (Specify) _____

_____

What happens if this routine is disrupted?

Impact on child: _____

Impact on family members: _____

FEEDING- Does your child currently have any feeding difficulties? Yes____ No____

Was your child breastfed as an infant? Yes _____ No _____

For how long? _____

If child was bottle fed as an infant, were there any difficulties or concerns? Yes _____ No _____

Please comment _____

Did your child have a strong suck as an infant? Yes _____ No _____

Please comment _____

Did you child frequently spit up as an infant or have reflux? Yes _____ No _____

Please comment _____

Did your child have problems with appetite or weight gain as an infant? Yes _____ No _____

Please comment _____

Did you child have respiratory problems as an infant? Yes _____ No _____

Please comment _____

Does your child avoid/limit food based on the following characteristics? Yes _____ No _____

Variety of food selection _____ Temperature _____ Food texture _____ Crunchy foods _____

Chewy foods _____ Food color _____ Mixed food textures _____ Other(s) _____

Does your child show strong preferences for food based on the following characteristics? Yes _____ No _____

Variety of food selection _____ Temperature _____ Food texture _____ Crunchy foods _____

Chewy foods _____ Food color _____ Mixed food textures _____ Other(s) _____

Does your child have difficulty with ingesting foods? Yes _____ No _____

Chewing variety of foods _____ Sucking through a straw _____ Swallowing variety of foods _____

Other(s) _____

Is there a disruption in family mealtime as a result of atypical eating patterns? Yes _____ No _____

Please comment _____

Does your child exhibit oral motor seeing sensitivities or seeking? Yes _____ No _____

Examines objects by placing in mouth _____ Gags/vomits frequently _____

Bites/chews objects/clothing frequently _____ Grinds teeth _____ Other(s) _____

Does your child attempt to eat unusual, noxious, or inedible substance or place in mouth? Yes _____ No _____

Please comment _____

How long does your child sit at mealtime? 1-2 mins _____ 3-5 mins _____ 6-10 mins _____ Entire meal _____

Does this impact the quantity of food ingested? Yes _____ No _____

How does this impact harmony at mealtimes? _____

Where does your child eat meals? _____

What routines do you follow that are helpful for getting your child to eat meals?

_____

What happens if this routine is disrupted?

Impact on child _____

Impact on family members _____

GROOMING

Does your child have difficulty with grooming activities? Yes____ No____

Tooth brushing _____ Bathing _____ Hair brushing/combing _____ Face washing _____ Haircuts _____

Nail trimming _____ Blowing nose _____ Other(s) _____

Does your child avoid grooming devices?

Electric toothbrushes _____ Barber's clippers _____ Dentistry tools _____ Other(s) _____

What routines do you follow that are helpful for getting your child to participate in grooming activities?

_____

What happens if this routine is disrupted?

Impact on child _____

Impact on family members _____

DRESSING- Does your child currently have difficulty with dressing? Yes____ No____

Which clothing is your child able to take off independently?

Shirt _____ Pants _____ Underwear _____ Shoes _____ Socks _____ Coat _____

Which clothing is your child able to put on independently?

Shirt _____ Pants _____ Underwear _____ Shoes _____ Socks _____ Coat _____

Which fasteners can your child manage independently?

Snaps _____ Zippers _____ Buttons (unbutton & button) _____ Ties shoes _____

Was it a struggle learning to tie shoes? Yes _____ No _____

Is your child selective in the types of clothing textures he/she will wear? Yes _____ No _____

What types of clothing textures are preferred?_____

What clothing textures are avoided? _____

Does your child prefer to wear minimal clothes, regardless of weather? Yes _____ No _____

Please comment _____

Does your child prefer clothing to cover entire body/dress in layers, regardless of weather? Yes _____ No ____

Please comment _____

Does your child frequently adjust clothing, as if uncomfortable? Yes _____ No _____

Please comment _____

Do tags in clothing or seams in socks bother your child? Yes _____ No _____

What type of reaction/behavior is seen? _____

What routines do you follow that are helpful for getting your child to participate with dressing?

_____

What happens if this routine is disrupted?

Impact on child _____

Impact on family members _____

TOILET TRAINING

Is your child currently toilet trained for bladder? Yes _____ No _____

Is your child currently toilet trained for bowel? Yes _____ No _____

Does your child experience urinary/bowel issues? Yes _____ No _____

Incontinence during the day _____ How often? _____

Bedwetting _____ How often? _____

Constipation _____ How often? _____

Loose stools _____ How often? _____

Lack of awareness _____ How often? _____

Does your child wear a diaper or pull-up at night? Yes _____ No _____

What routines do you follow that are helpful for getting your child to participate with toilets?

_____

What happens if this routine is disrupted?

Impact on child _____

Impact on family members _____

SOCIAL FUNCTIONS/FAMILY LIVING

Are you limited in attending family/social gatherings because of your child's behavior/reactivity to events?

Yes _____ No _____ Please comment _____

Does your child have difficulty at birthday parties? Yes _____ No _____

Please comment _____

Are you able to leave your child alone with familiar, but not routine, caregivers for childcare?

Yes _____ No _____ Please comment _____

Is your family able to maintain relationships with other families? Yes _____ No _____

Please comment _____

Is your family able to pursue hobbies and interests? Yes _____ No _____

Please comment _____

What routines do you follow that are helpful for getting your child to participate in social situations?

_____

What happens if this routine is disrupted?

Impact on child _____

Impact on family members _____

COMMUNITY

Is your child able to eat out at restaurants? Yes _____ No _____

Please comment _____

Is your child uncomfortable on elevators, escalators, or in cars? Yes _____ No _____

Please comment _____

Does your child avoid busy, unpredictable environments? Yes _____ No _____

Please comment _____

Does your child have an excessive reaction to light touch sensations? Yes _____ No _____

What types of reaction/behaviors is seen? _____

Is your child unresponsive to being touched or bumped? Yes _____ No _____

Does your child have an excessive reaction if bumped unexpectedly? Yes _____ No _____

Please comment _____

Does your child exhibit a lack of safety awareness? Yes _____ No _____

Please comment _____

Does your child have difficulty traveling on a variety of public transportation? Yes _____ No _____

Please comment _____

Does your child have difficulty flying on airplanes? Yes _____ No _____

Please comment _____

Is your child able to have successful playdates? Yes _____ No _____

Please comment _____

Does your child have difficulty with loud, crowded sporting events? Yes _____ No _____

Please comment _____

Does your child have difficulty sitting through public performances? Yes _____ No _____

Please comment _____

Does your child have difficulty in the grocery stores? Yes _____ No _____

Please comment _____

Does your child have difficulty with long car rides? Yes _____ No _____

Please comment _____

Does your child have difficulty standing in lines? Yes _____ No _____

Please comment _____

SOCIAL INTERACTION

Does your child exhibit aggressive behavior? Yes _____ No _____

Is it directed towards him/herself? Yes _____ No _____

Is it directed towards others? Yes _____ No _____

What types of behaviors are exhibited? Biting _____ Pinching _____ Kicking _____ Hitting _____

Other(s) _____

Does your child exhibit tantrums? Yes _____ No _____ Are you concerned about this? Yes____ No____

How frequently do they occur? _____ times/day _____ times/week

How long do they last? _____minutes

What triggers the tantrums? _____

Describe strategies that are effect for helping calm your child during a tantrum _____

_____

Are tantrums a source of distress to other family members? Yes _____ No _____

Is your child easily frustrated? Yes____ No____
Is your child anxious? Yes____ No_____ What makes them anxious?_____
Is your child easily overwhelmed? Yes _____ No _____ By what?_____
Is your child over dependent on parent(s) or clingy? Yes _____ No _____
Are separations challenging? Yes _____ No____

Does your child easily escalate from whimper to intense cry? Yes _____ No _____

Please comment _____

_____

If your child uses atypical repetitive behavior, which behavior are demonstrated?

Hand flapping _____ Rocking _____ Head banging _____ Jumping _____ Smelling _____

Breath holding _____ Humming _____ Self-talk _____ Biting _____ Mouthing objects _____

Visual fixing _____ Spinning _____ Teeth grinding _____ Other(s) _____

Does your child struggle with transitions between activities? Yes _____ No _____ Are you concerned?_____

How long does it take to transition, on average? _____

What transitions are difficult? _____

What strategies are used to help ease transitions? _____

Does difficulty transitioning cause distress to family members? Yes _____ No _____

Please comment _____

Does your child struggle when there is excessive auditory input in his/her environment? Yes _____ No _____

How does your child react? _____

Does your child struggle around individuals with certain voice pitches? Yes _____ No _____

Please comment _____

Does your child struggle to communicate own needs? Yes _____ No _____

Please comment _____

What is your child's primary form of communication?

Talking _____ Signing _____ Sounds/Vocalizations _____ Pointing/Gesturing _____

Crying/Screaming _____ Other(s) _____

How often does your child make eye contact during conversations?

Less than 25% of the time _____ 25% of the time _____ 50% of the time _____

75% of the time _____ 100% of the time _____

How often does your child orient to his/her name being called?

Less than 25% of the time _____ 25% of the time _____ 50% of the time _____

75% of the time _____ 100% of the time _____

Does your child have difficulty separating from parent or caregiver? Yes _____ No _____

Please comment _____

Does your child appear to have an awareness of others? Yes _____ No _____

Does your child appear to have an awareness of self? Yes _____ No _____

Does your child lack fear of strangers? Yes _____ No _____

How does your child react in new/unfamiliar situations? _____

Does your child have difficulty paying attention in noisy environments? Yes _____ No _____

Please comment _____

Does your child regularly avoid initiation of social interaction? Yes _____ No _____

With whom? _____

How often? _____

Does your child avoid maintaining social interactions? Yes _____ No _____

With whom? _____

How often? _____

Does your child experience difficulties with language expression? Yes _____ No _____

Easily frustrated, anxious or overwhelmed _____ Frequently mispronounces words (i.e. bisghetti) _____

Poor articulation, difficult to understand _____ Difficulty making choices _____

Flat, monotonous voice _____ Hesitant speech _____ Tendency to stutter _____

Difficulty expressing emotions verbally _____

What routines do you follow that are helpful for getting your child to socialize?

_____

What happens if this routine is disrupted?

Impact on child _____

Impact on family members _____

PLAY SKILLS/PEER INTERACTION

Is your child destructive towards toys? Yes _____ No _____ Please comment _____

Does your child struggle to play alone (excluding TV watching)? Yes _____ No _____

Please comment _____

How long is your child able to play alone?

1-2 mins _____ 2-5 mins _____ 5-10 mins _____ 10-30 mins _____ 30+ mins _____

What are your child's preferred play activities? _____

_____

How much time is spent daily in the following activities?

Passive activities (i.e. TV, computer, etc.) _____

Movement activities (i.e. playground, roughhouse play, etc.) _____

Learning/interactive play _____

Does your child struggle playing with other children? Yes _____ No _____ (check the areas where they struggle)

Parallel play – playing alongside other children _____

Interactive play – playing with other children _____

Structured group play _____

Making friends _____

Pretend play _____

Is your child preoccupated with seeking intense movement during play? Yes _____ No _____

Spinning _____ Bouncing _____ Crashing _____ Jumping _____ Rocking _____ Other(s) _____

Does your child have a strong desire for structure or control? Yes _____ No _____

Please comment _____

Does your child struggle to play in familiar settings? Yes _____ No _____

Please comment _____

Does your child struggle to play in unfamiliar settings? Yes _____ No _____

Please comment _____

Which playground equipment will your child play on?

Swings _____ Monkey bars _____ Crawl tunnels _____ Vertical climbers _____ Merry-go-round _____

Ladders _____ Slide _____ Climbing wall _____ Bridges _____ Teeter totters _____ Spring riders _____

Other(s) _____

Which playground equipment does your child avoid?

Swings _____ Monkey bars _____ Crawl tunnels _____ Vertical climbers _____ Merry-go-round _____

Ladders _____ Slide _____ Climbing wall _____ Bridges _____ Teeter totters _____ Spring riders _____

Other(s) _____

Does your child avoid certain types of toys (i.e. textured toys) Yes _____ No _____

Please comment _____

Does your child exhibit poor safety awareness or engage in activities that are potentially dangerous (i.e. jumping without regard)? Yes _____ No _____

Please comment _____

Which of the following “messy” activities does your child avoid?

Sand _____ Playing in the grass _____ Finger paint _____ Play-doh _____ Glue _____ Other(s) _____

Which surfaces does your child have difficulty with?

Ascending stairs _____ Descending stairs _____ Grass _____ Gravel driveways _____ Woodchips _____

Sand _____ Other(s) _____

Does your child have poor depth perception (i.e. ducks or blinks with ball is thrown at him/her, difficulty with stairs)? Yes _____ No _____

Do you have concerns with your child's gross motor skills or physical abilities? Yes____ No____

Which gross motor skills does out child have difficulty with in comparison to age peers?

Hopping _____ Jumping _____ Skipping _____ Running _____ Riding a tricycle/bicycle _____

SCHOOL SKILLS

Does your child exhibit a hand preference? Yes _____ No _____

Right _____ Left _____ Established at what age? _____ Does your child frequently chan ge his/her grasp on pencils/other tools? Yes _____ No _____

Which writing skills does your child struggle with/avoid?

Drawing/coloring _____ Tracing _____ Copying _____ Handwriting _____

Use of graded pressure: Too much _____ Too little _____

Stabilization of while drawing/writing _____ Proper desk posture _____

Which fine motor skills does your child struggle with/avoid?

Grasping and maneuvering a scissor _____ Performing 2 different tasks at the same time (i.e. hold and turn paper while cutting, cut food using knife and fork) _____

Which skills does your child struggle with?

Finding items within a "Hidden picture" _____ Phonetic learning _____ Telling time _____ Spelling _____

Sequencing months of the year _____ Puzzles and construction/manipulation of materials _____

Responding promptly to verbal instructions _____

Writing numbers & letters correctly (without frequent reversals) _____

Is your child's draw-a-person immature for age? Yes _____ No _____

Does your child write up/down hill on paper? Yes _____ No _____

Which of the following visual-related skills does your child struggle with?

Poor eye teaming _____ Using peripheral more than central vision _____

Keeping eyes too close to work _____ Closing/covering one eye while doing near work _____

Eye strain after reading a short period of time _____ Copying from chalkboard to paper _____

Short attention span in reading/copying _____ Turning head when reading across a page _____

Losing place often during reading _____ Needing finger or marker to keep place while reading _____

Reading comprehension _____ Reverse letters or words _____ Rereads or skips words _____

Doesn't look when manipulating objects _____ Tracking a moving object with head movement _____

Does your child have difficulty sitting still? Yes _____ No _____

Does your child fidget while listening? Yes _____ No _____

MOVEMENT SKILLS

Does your child become overly excited after movement activity? Yes _____ No _____

Please comment _____

Does your child display the following movement difficulties? (check all that apply)

Avoids activities where feet leave the ground _____

Avoids/fears activities requiring balance _____

Avoid age appropriate gross motor activities _____

Loses balance/trips easily or frequently _____

Dislikes being moved _____

Drags hand or bangs object along wall when walking _____

Stomps/slaps feet on ground when walking _____

Drags feet or has poor heel-toe pattern when walking _____

Unable to reciprocate feet on stairs _____

Excessive dizziness from swinging, spinning, or riding in a car _____

Resists having head tilted backwards _____

Fears falling when no real danger exists _____

Fearful of being tossed in the air or turned upside down _____

Holds head upright when leaning or bending over _____

Dislikes inversion _____

Confuses left and right _____

Lethargic or inactive _____

Difficulty moving between rooms _____

Difficulty moving from one floor surface to another _____

Poor body scheme awareness _____

Leans on objects/people for stability _____

Poor sense of direction or awareness of space in relation to self _____

Limited rotation of pelvis and/or shoulder girdle around central core of body _____

Moves with quick bursts of activities rather than sustained effort _____

Sets jaw or locks major joints for stability when applying effort _____

Seems weaker or tires more easily than peers _____

Poor coordination or sense of rhythm _____

Does your child like to be wrapped tightly in a sheet or blanket, or seek tight spaces? Yes _____ No _____

Does your child shake head vigorously or assume an upside-down position frequently? Yes _____ No _____

Is your child able to conceive and organize a plan of action to direct play/movement? Yes _____ No _____

DAILY ENVIRONMENT INTERACTION

Does your child demonstrates an irrational fear of any of the following noisy appliances?

Vacuum cleaner _____ Hair dryer _____ Fans _____ Blender _____ Coffee grinder _____

Toilet flushing _____ Dehumidifier _____ Air vents _____ Other(s) _____

Please comment _____

Does your child demonstrates an irrational fear of any of the following noisy sounds?

Jets/Airplanes _____ Trucks _____ Thunder _____ Other(s) _____

Please comment _____

Is your child confused about the direction of sounds? Yes _____ No _____

Please comment _____

Does your child hear sounds that others do not or before others notice? Yes _____ No _____

Please specify _____

Does your child cover ears to shut out objectionable auditory input or overreact to unexpected noises?

Yes _____ No _____

Please comment _____

Does your child attend to auditory input less than a few seconds? Yes _____ No _____

Please comment _____

Does your child appear under or over sensitive to pain? Yes _____ No _____

Please comment _____

Does your child dislike having eyes covered or being in the dark? Yes _____ No _____

Please comment _____

Is your child overly sensitive to lights/sunlight? Yes _____ No _____

Please comment _____

Does your child seem to need to "fix" the environment (i.e. arrange objects, chairs, etc.)? Yes _____ No _____

Please comment _____

Does your child avoid environments/objects with certain odors? Yes _____ No _____

Please comment _____

Does your child seek environments/objects with certain odors? Yes _____ No _____

Please comment _____

GOALS

What are your goals for your child? What do you wish and want OT to help with? Please be very specific.

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

Signature: _____ Date: _____

Parent or Guardian Name: _____

How did you hear about this practice? _____

If you were referred:

Referred by: _____ Profession: _____