# Little Harbor Therapy

**Child Case History**

Today's Date:

Child's Name: Date of Birth:

Address:

City: Zip:

Mother's Name: Date of Birth:

Mother's Occupation: Phone:

Father's Name: Date of Birth:

Father's Occupation: Phone:

Email: I prefer: ○ Call ○ Text ○ Email

With whom does the child live?:

Brothers and sisters (include names and ages):

Referred by:

Physician: Phone:

Other therapies/services received:

Describe your goals for Occupational Therapy:

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**Prenatal and Birth History**

Describe mother's general health during pregnancy (illnesses, accidents, prescription and non-prescription medications, etc.)

Length of pregnancy: Length of labor:

Child's general condition: Birth weight:

Type of delivery: ○ Head first ○ Feet first ○ Breech ○ Cesarean

Were forceps used? Child's length of hospital stay:

Describe any unusual conditions that may have affected the pregnancy or birth.

**Medical History**

Please describe your child's past and current medical history, including frequent ear infections and general health:

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Current medication(s) and dosage(s).

Describe any major accidents, surgeries, or hospitalizations :

**Developmental History**

Write the approximate age when the child began to do the following:

Crawl: Sit Unsupported: Stand: Walk:

Feed Self: Dress Self: Use toilet:

Describe level of assistance needed to complete the following activities

(cues, little help, moderate help, lots of help):

Put on shirt: Put on shorts: Put on socks:

Put on shoes: Use toilet: Wash hands:

Use fork: Use spoon: Brush teeth:

Fasten/zip pants: Tie shoes (if applicable):

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**General Behavior**

Describe child's eating habits (Picky eater? Dislike certain textures?)

Special Diet/Allergies?:

Describe child's sleep habits:

How does the child interact with other family members?

Favorite toys/games:

Any other comments on behavior (aggression, self-injury, coping style):

**Educational History**

School or Preschool: Grade:

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Describe any special services your child receives:

If enrolled for special education services please provide a copy of their most current Individualized Educational Plan (IEP) or Individual Family Service Plan (IFSP).

Please add any additional information you feel might be helpful in the evaluation or treatment:

Person completing the form:

Relationship to the child:

Signed:_____

Date:_____

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