My Pediatric OT Services

Helping kids help themselves

Medical History

Date: _____

Child's Name: _____

Date of Birth: _____

Please list any medical or school evaluations (copies of the evaluation report are greatly appreciated) your child has completed and any diagnoses that may have been given:

_____

_____

_____

_____

Has your child had a current hearing evaluation, yes, when and describe results:

_____

Has your child had a current vision evaluation, if yes, when and describe results:

_____

Please list any current medications:

_____

_____

_____

Has your child ever received or is currently participating in (please check all that apply and list organization/services provided):

- ☐ Early Intervention _____
- ☐ Occupational Therapy _____
- ☐ Physical Therapy _____
- ☐ Speech services _____
- ☐ Counseling _____
- ☐ ABA _____

Does your child have any allergies (food, medication, etc.)? ☐YES ☐NO

If, yes, please list: _____

_____

_____

1776 Washington Street, Walpole, MA 02081

(508) 208-8438 www.mypediatricOTservices.com

Is your child on a special diet? ☐ YES ☐ NO
If, yes, please describe:

Is your child enrolled in an educational program? ☐ YES ☐ NO
If, yes, please note that program and address:

Do you have any academic or social concerns at this time? ☐ YES ☐ NO
If, yes, please describe:

Birth/Early Childhood History

Length of Pregnancy: _____ weeks

Delivery and complications, if any:

Child's birth weight:

Did your child experience any post-natal difficulties?

Did you child spend any time in the Neonatal Intensive Care Unit? ☐ YES ☐ NO
If, yes, please describe:

Does your child have a history of (please check all that apply):

- ☐ Gastroesophageal Reflux (GERD)
- ☐ Intrauterine Growth Restriction (IUGR)
- ☐ Torticollis
- ☐ Premature birth
- ☐ Vision impairment
- ☐ Hearing impairment
- ☐ Respiratory impairment

When did your child start to (approximations are okay):

Roll: _____
Sit independently: _____
Crawl: _____
Walk: _____
Jump: _____
Climb stairs: _____

Is your child able to:

	YES	NO	Sometimes
Take off clothing items	☐	☐	☐
- Socks/shoes	☐	☐	☐
- Pants	☐	☐	☐
- Shirt	☐	☐	☐
- Coat	☐	☐	☐
Put on clothing items	☐	☐	☐
- Socks/shoes	☐	☐	☐
- Pants	☐	☐	☐
- Shirt	☐	☐	☐
- Coat	☐	☐	☐
Participate in teeth brushing	☐	☐	☐
Participate in bathing	☐	☐	☐
Drink from an open cup	☐	☐	☐
Use a straw	☐	☐	☐

Please describe your child's current toileting status (independent, diapers, practicing, refuses, withholds, etc.):

_____
_____
_____

Please describe your child's current sleep routine and status (falls asleep independently, but trouble staying asleep; restless; sleeps in their own room; shares a room with sibling, etc.):

_____
_____
_____

What are your child's preferred toys/activities:

_____
_____
_____

Please list and/or attach any other important information you would like to share with us: