



OCCUPATIONAL THERAPY CLIENT INFORMATION FORM

Child's Name: _____ Date of Initial Session: _____

What other services are you currently receiving/have you received in the past?

If yes, where and what services? Please include dates:

Physical Therapy: _____ Speech Therapy: _____

Occupational Therapy: _____ Other Physician besides Primary Medical Physician: _____

MEDICAL/SOCIAL HISTORY

Were there any complications during pregnancy? Yes ___ No ___

Were there any complications during birth? Yes ___ No ___

If yes, please explain: _____

Pregnancy was: _____ weeks Birth weight was: _____ pounds

Please list any illness, diagnoses, surgeries, and/or injuries?

Does your child have any allergies? Yes ___ No ___

If yes, please explain if they are managed, and any behavior/s exhibited as a result?

Does your child have a history of ear infections? Yes ___ No ___

If yes, please explain: _____

Has your child's vision been tested? Yes ___ No ___

Date Tested (if known): _____ By whom: _____

Have there been any significant changes in your family recently (e.g., moving, deaths, divorce, or births)? _____

Did your children meet the typical developmental milestones? Yes ___ No ___

If no, please explain: _____

SCHOOL

Does your child attend school, homeschool, or daycare? Please specify: _____

Is your child receiving any support services at school? Yes ___ No ___

Please specify: _____

Does your child have any other problems that may affect learning? _____



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What are your child's strengths?

What are your child's interests?

Does your child have particular dislikes or fears?

What are your concerns about your child?

What have you been told by doctors, teachers, and/or others about your child's abilities and needs?

What do you hope will be gained by having your child seen for occupational therapy?

Parent Signature: _____ **Date:** _____