# BACKGROUND INFORMATION and OCCUPATIONAL HISTORY

(This form is intended to be completed by the child's parents or primary caregivers)

**FAMILY INFORMATION**

Child's Name: _____ Today's Date: _____
Birth date: _____ Age: _____ years _____months Home Phone: _____
Address:_____
E-mail address_____
Mother's Name: _____ Age: ___Occupation: _____Office/Cell Phone: _____
Father's Name: _____Age: ___ Occupation: _____Office/Cell Phone: _____
With whom does child live most of the time?
Biological Parent: Mother [ ] Father [ ] Step-parent: Mother [ ] Father [ ]
Adoptive Parents [ ] (Adopted at what age: _____Other [ ] (Specify: _____
Grandparents [ ] Other _____
Siblings: how many? [ ] Name _____ Age _____Health _____
*(use other side* Name _____ Age _____Health _____
*for additional info)* Name _____ Age _____Health _____

**REFERRING INFORMATION**

Who **referred** this child for an evaluation? _____
**Reason** for referral: _____
_____
When did you first have those **concerns**? _____
_____
What do you see as your child's **strengths**?_____
_____
_____
In one sentence, how would you **describe your child**? _____
_____
Do you have any **additional information** that will help to better understand your child?
_____
What are your primary **goals** regarding this evaluation? _____
_____
_____

**SCHOOL HISTORY:**

Hand preference: _____Current school placement:_____
Present grade: _____ Have any grades been repeated? _____
Is your child in a special class or receiving any support services (specify)?
_____
What does the teacher say about your child?
_____

**INTERVENTION HISTORY:** Please check any of the following with whom you have contacted concerning your child and include name and contact information if possible.

[ ] Occupational Therapist _____
[ ] Physical Therapist_____
[ ] Speech and Language Pathologist _____
[ ] Developmental Pediatrician _____
[ ] Developmental Optometrist_____
[ ] Behaviorist_____
[ ] Orthopedist_____
[ ] Psychologst_____
[ ] Counseling _____
[ ] Others (please specify)_____

**MEDICAL HISTORY**

Any difficulties during pregnancy or delivery? (Specify)_____

_____

Length of pregnancy: _____ Length of labor: _____

Birth was: Normal [ ] Caesarian [ ] Breech [ ] Twins or more [ ]

Birth Weight: _____ Did baby require assistance in starting to breathe? Yes [ ] No [ ]

Remarks: _____

Were there any complications/problems in early infancy? Yes [ ] No [ ] (please specify)

_____

_____

Were there any feeding difficulties in early infancy? Yes [ ] No [ ] (please specify)

_____

_____

Who is your child's present physician? _____

Does your child have a diagnosis?_____

Diagnosed by whom?_____Date: _____

Does your child have now or in the past had significant health problems?

Surgery? Explain_____Hospitalization,? Explain_____

Respiratory, Lung or bronchial difficulties?_____Cardiac Problems?_____

Seizures (when and how often) _____

Allergies?_____Ear Infections?_____

Is your child currently on any medications? Yes [ ] No [ ]

(If yes, please give a list and state reasons)

_____

Previously tried medications_____

Does your child use any specialized equipment? (Explain)

_____

Has your child had a hearing evaluation? Yes [ ] No [ ]

By whom: _____ Date:_____

Has your child had a vision evaluation? Yes [ ] No [ ]

By whom: _____ Date:_____

Has your child had a psychological evaluation? Yes [ ] No [ ]

By whom: _____Date:_____

Has your child had a neurological evaluation? Yes [ ] No [ ]

By whom: _____Date:_____

**DEVELOPMENTAL HISTORY**

Children sometimes act or appear younger than their chronological age. What age do you think best describes your child and why? _____

_____

List the age at which your child accomplished each activity.
Indicate "not yet', if they have not yet accomplished it.

**Motor:**

Head control
Roll over both ways _____
Sitting alone _____
Creeping on all 4's
Pulling to stand _____
Walking _____
Jumping _____
Hopping on one-foot _____
Riding bike _____

Reaching for objects _____
Finger Feeding _____
Eating with spoon _____
Drawing a circle _____
Cutting with scissors _____
Using knife for cutting _____

Does your child have difficulty learning new motor skills? _____

**Language:**

Said first word _____
Combined words _____
Spoke sentences _____
Looking when called _____

Pointing to simple pictures _____
Following one-step commands _____
Following several-step commands _____
Looks in direction that others point _____

**Self-Help:**

**Dressing**
Put on shirt independently _____
Button independently _____
Zips independently _____
Snaps independently _____
Dress self independently _____

**Grooming**
Bathing independently _____
Combing hair _____
Toilet trained Bowel _____
Bladder _____
Toileting independently _____
Ties shoes _____

| **Describe your child as an infant:** | **YES** | **NO** | **SOMETIMES** |
|---|---|---|---|
| A. Cried a lot, fussy, irritable | | | |
| B. Non-demanding | | | |
| C. Alert | | | |
| D. Quiet | | | |
| E. Passive | | | |
| F. Active | | | |
| G. Liked being held | | | |
| H. Resisted being held | | | |
| I. Floppy when held | | | |
| J. Tense when held | | | |
| K. Good sleep patterns | | | |
| L. Irregular sleep patterns | | | |

| **Describe your child at present:** | **YES** | **NO** | **SOMETIMES** |
|---|---|---|---|
| | | | |
| A. Mostly quiet | | | |
| B. Overly active | | | |
| C. Tires easily | | | |
| D. Talks constantly | | | |
| E. Too impulsive | | | |
| F. Restless | | | |
| G. Stubborn | | | |
| H. Resistant to changes | | | |
| I. Fights frequently | | | |
| J. Usually happy | | | |
| K. Exhibits frequent temper tantrums | | | |
| L. Clumsy | | | |
| M. Difficulty separating from primary caretaker | | | |
| N. Nervous habits or tics | | | |
| O. Falls often | | | |
| P. Wets bed | | | |
| Q. Wets or soils pants (how often) | | | |
| R. Has poor attention span | | | |
| S. Frustrated easily | | | |
| T. Has unusual fears | | | |
| U. Rocks self frequently | | | |
| Comments: | | | |

**How well does your child do the following?**
Sleeping:

Eating:

Toileting:

Playing:

Behaving:

**If and when you discipline your child, what do you do?**

**What do you do that works the best to obtain cooperation from your child?**

**Family Impact Questionnaire (Pilot)**

Name of child receiving services _____Age: _____
Diagnosis (if applicable) _____ Date: _____
Number of years child has received therapy services _____ overall_____
Programs in which your child has participated (circle all that apply):
OT PT Speech Early Intervention - Special Education Other____
Person completing the questionnaire:_____
Relationship to child: mother _____ father _____other (specify) _____

**Please answer the following questions in relation to how things are going for your child and family now. Think about the last month or so (rather than the entire last year or just the last day or two.) If your child has been sick, or has experienced some unusual event (e.g. the loss of a long time caregiver) try to answer the questions in terms of how things were going just before this event.**

| | ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER | NOT APPLICABLE |
|---|---|---|---|---|---|---|
| **1. Does your child:** | | | | | | |
| a. play with friends? | | | | | | |
| b. make and keep friends? | | | | | | |
| c. relate to being part of the family? | | | | | | |
| d. interact and play with siblings? | | | | | | |
| e. interact with parents and significant adults? | | | | | | |
| f. communicate needs, wants, and interests effectively? | | | | | | |
| g. "fit in" with peers? | | | | | | |
| **2. How often do the following daily household routines run smoothly for your child and family?** | | | | | | |
| a. getting ready to go somewhere | | | | | | |
| b. leaving the house in the morning | | | | | | |
| c. meal preparation and cleanup | | | | | | |
| d. mealtimes | | | | | | |
| e. getting ready for and going to bed | | | | | | |
| f. bathing and grooming activities | | | | | | |

| | ALWAYS | OFTEN | SOMETIMES | RARELY | NEVER | NOT APPLICABLE |
|---|---|---|---|---|---|---|
| **3. How often do the following experiences go smoothly for your child and family?** | | | | | | |
| a. running errands | | | | | | |
| b. leaving to go out on overnight trips | | | | | | |
| c. shopping trips for groceries or clothes | | | | | | |
| d. dining out | | | | | | |
| e. birthday parties | | | | | | |
| f. recreational activities such as bike riding or ball games | | | | | | |
| g. family outings such as going to the park, museum or the movies | | | | | | |
| h. family gatherings (e.g. holidays, weddings, birthdays, etc.) | | | | | | |
| i. vacations | | | | | | |
| j. spontaneous outings | | | | | | |
| k. following through with plans (i.e. not having to cancel at the last minute) | | | | | | |
| l. taking your child with you rather than leaving him or her at home | | | | | | |
| 4. **Considering your child's special needs, is your family able to:** | | | | | | |
| a. find and keep a babysitter | | | | | | |
| b. socialize with extended family? | | | | | | |
| c. socialize with friends? | | | | | | |
| d. stay involved with the community? | | | | | | |
| e. participate in the neighborhood? | | | | | | |

**Comments: (Please include any areas that you think are significant for your family. Use other side if necessary)**

Describe a typical day for your child from waking till bedtime including whether it is different for your child to get to sleep at night and stay asleep. (Use back of page if necessary)_____

_____

_____

_____