OCCUPATIONAL THERAPY
Helping Children

CONFIDENTIAL PERSONAL HISTORY
FOR CHILDREN AND YOUNG ADULTS

Today's Date: _____ Completed by: _____
Last Name: _____ Child's Name: _____
Address: _____ Birthdate: _____
Gender: _____ Age: _____

CONTACT INFORMATION

Parent A's Name _____ Parent B's Name _____
Address: _____ Address: _____
Home phone: _____ Home phone: _____
Mobile phone: _____ Mobile phone: _____

Emergency Contact: _____
Name Relationship Phone

School: _____ **Year in School:** _____
Teacher's Name _____ Type of Classroom: _____

Child's GP Allied Health Providers

Name: _____ Profession: _____ Phone: _____
Email: _____
Name: _____ Profession: _____ Phone: _____
Email: _____
Name: _____ Profession: _____ Phone: _____
Email: _____

Are there any medical precautions the therapist should be aware of when working with your child?

_____
_____

FAMILY MEMBERS - Detailed Information

		Age	Sex	Adopted		Occupation	Handedness	
Father	_____	_____	_____	☐Yes	☐No	_____	☐R	☐L
Mother	_____	_____	_____	☐Yes	☐No	_____	☐R	☐L
Siblings	_____	_____	_____	☐Yes	☐No	_____	☐R	☐L

Marital Status of Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other

Mother's Education
☐ Less than High School
☐ High School
☐ University
☐ Post Graduate

Father's Education
☐ Less than High School
☐ High School
☐ University
☐ Post Graduate

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PERSONALITY PROFILE

What are your child's gifts/ strengths? _____

What do you enjoy most about your child and family?

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? (Hobbies, sports, clubs)

Please list them in order of preference beginning with the favourite activity.

Has your child been diagnosed with (PLEASE CHECK ALL THAT APPLY):

- ☐ ADD
- ☐ ADHD
- ☐ Anxiety Disorder or Mood Disorder (Specify): _____
- ☐ Autistic Spectrum Disorder
- ☐ Cognitive Delay
- ☐ Down Syndrome
- ☐ Dyslexia
- ☐ Emotional disorder (Specify) : _____
- ☐ Fragile X Syndrome

- ☐ Learning Disabilities (Specify if possible): _____
- ☐ Sensory Processing Disorder or Sensory Integration Dysfunction
- ☐ Tourette's Syndrome
- ☐ Other (specify):

MEDICATIONS

List any medications that your child currently receives

Medication:	_____	Purpose:	_____	When taken:	_____
Medication:	_____	Purpose:	_____	When taken:	_____
Medication:	_____	Purpose:	_____	When taken:	_____

List any medications has your child received in the past:

Medication:	_____	Purpose:	_____	When taken:	_____
Medication:	_____	Purpose:	_____	When taken:	_____
Medication:	_____	Purpose:	_____	When taken:	_____

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?

_____

_____

PREGNANCY (If child is adopted, skip to Adoption Section)

	Yes	No	Comments
Was it planned?	☐	☐	_____
Were there complications?	☐	☐	_____
Shock	☐	☐	_____
Severe stress	☐	☐	_____
Loss of a loved one	☐	☐	_____
Accident	☐	☐	_____
Health problems, specify	☐	☐	_____
Confinement to bed	☐	☐	_____
Other	☐	☐	_____
Was mother exposed	☐	☐	_____
Did mother smoke?	☐	☐	_____
Did mother consume alcohol?	☐	☐	_____

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Did mother take any medication? specify	☐	☐	
Did mother talk much?	☐	☐	
Was mother physically active?	☐	☐	
Were any previous pregnancies complicated?	☐	☐	

LABOR AND DELIVERY

Describe your experience during labour and delivery

					Comments
Length of labour?		Hrs			
Premature: specify	☐Yes		☐No		
Forceps used	☐Yes		☐No		
High forceps required	☐Yes		☐No		
Suction	☐Yes		☐No		
Delivery position (ex: breech)					
Caesarean birth (reason)	☐Yes		☐No		
Birth weight		Lbs		Oz	
APGAR ratings (if known)					
Cried immediately	☐Yes		☐No		
Required special treatment (i.e. required oxygen, had jaundice, etc.		☐Yes		☐No	
Birth injuries: specify		☐Yes		☐No	
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 first two years of the child's life, what type of baby was he/she? (feeding, sleeping, activity level)

	Yes	No	Comments
Breastfeed	☐	☐	
Extended separations during first two years (over 3 days)	☐	☐	
Specific health problems during this period	☐	☐	

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Thumb sucking/ pacifier (until what age)	☐	☐	
Feeding problems	☐	☐	
Sleeping problems	☐	☐	
Colic or "Fussy baby"	☐	☐	
Prefer certain positions as an infant (describe)	☐	☐	
Dislike lying on stomach	☐	☐	
Dislike lying on back	☐	☐	
Able to self soothe	☐	☐	
On a regular schedule	☐	☐	
Enjoy bouncing	☐	☐	
Become calmed by car rides or infant swings	☐	☐	
Become nauseated by car rides or infant swings	☐	☐	
Crawled (at what age)	☐	☐	
Toe walker (until what age)	☐	☐	
Go through "terrible twos"	☐	☐	
Describe your child's toddler stage:	☐	☐	

CHILDHOOD ILLNESS/PROBLEMS

		Age	Comments/ Deficits
☐	Ear infections		None/ A Couple/ Many
☐	Tube in ears		
☐	Respiratory problems		
☐	High fever		
☐	Meningitis		
☐	Adenoid problems		
☐	Frequent colds		
☐	Strep throat		
☐	Allergies	If yes, please specify:	

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

Asthma	☐	
Bronchitis	☐	
Skin problems	☐	
Gastro- Intestinal problems	☐	
Seizures	☐	
Epilepsy	☐	
Nightmares	☐	
Sleep	☐	
Bedwetting	☐	
Nail Biting	☐	
Broken limbs	☐	
Other	☐	

Has he/she ever been hospitalised? 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? _____

DEVELOPMENTAL MILESTONES

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

Rolling over		Walk		Say words	
Sit alone		Chew solid food		Say sentences	
Crawl		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? (operations, infections, tubes)

Ear infections? Seldom ☐ Sometimes ☐ Often ☐

Mild ☐ Moderates ☐ Severe ☐

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

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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, and 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 AND MOTOR DEVELOPMENT

Please check any that apply:

☐ My child seems to be overly sensitive to sensory experiences more so than most people:
☐ auditory ☐ tactile ☐ visual ☐ movement ☐ taste ☐ smell

☐ My child doesn't seem to react to sensory experiences as readily as most people:
☐ auditory ☐ tactile ☐ visual ☐ movement taste ☐ smell

☐ My child actively seeks out sensory experiences more so than most people:
☐ auditory ☐ tactile ☐ visual ☐ movement ☐ taste ☐ smell

☐ My child has difficulty differentiating sensory experiences.
(ex. confuse sounds, can't find objects in drawer or bag without looking, bumps into things)

Describe: _____

☐ My child has trouble learning new movements.

☐ My child tends to be clumsy and has balance and coordination problems.

PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENT?

Please attach relevant reports.

	ASSESMENTS			**TREATMENT**		
	Yes	No	Place/Date	Yes	No	Place /Date
Medical	☐	☐		☐	☐	
Audiological	☐	☐		☐	☐	
Speech	☐	☐		☐	☐	
Educational	☐	☐		☐	☐	
Psychological	☐	☐		☐	☐	
Occ. Therapy	☐	☐		☐	☐	
Other	☐	☐		☐	☐	

Comments: _____

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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?

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

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 present 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/Day care

Primary (K-Yr. 3)

Junior (Yr. 4-6)

High School (Yr. 7-12)

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

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GOALS

What are your goals for your child's program? Please be as specific as possible.

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

How did you hear about **Occupational Therapy Helping Children**?
If you were referred:

Referred by: _____ Profession: _____
Address: _____

OTHC has my permission to send a thank you letter to my referral source indicating my child has been for an evaluation.

Parent or Guardian: _____ Date: _____

Please return this document to hello@occupationaltherapy.com.au