Allied Rehab
Speech, Occupational & Physical Therapy

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OCCUPATIONAL THERAPY HISTORY FORM

Child's Name _____ Current Age _____

Can your child independently… (Check all that apply):

- ☐ Dress himself/herself?
- ☐ Button buttons?
- ☐ Put on their socks?
- ☐ Manage their pants during toileting?
- ☐ Brush/comb their hair?
- ☐ Snap snaps?
- ☐ Start and zip zippers?
- ☐ Tie their shoes?
- ☐ Brush their teeth?
- ☐ Wash hands/face?

Is your child a picky eater? Yes ☐ No ☐ If yes, please list the foods your child will eat:

_____

What utensils can your child use independently to eat/drink?

Check all that apply: ☐ fingers ☐ fork ☐ spoon ☐ sippy cup ☐ bottle ☐ open cup ☐ straw

Does your child have difficulty transitioning between activities (from toy to toy, leaving home/school to run errands, stop playing for mealtime, etc.?) Yes ☐ No ☐ If yes, please explain.

_____

Which hand does your child use more ? Right ☐ Left ☐ Both equally ☐

Does your child …(Check all that apply):

- ☐ Give up easily with fine motor activities?
- ☐ Get frustrated quickly with puzzles, writing and games?
- ☐ Dislike playing with small or manipulative toys?
- ☐ Seem not interested in scribbling or coloring?
- ☐ Have difficulty or refuse to grasp onto small objects?
- ☐ Prefer to sort toys by color or size rather than play with toys as they are intended?
- ☐ Tend to repeat the same action over and over with a toy (shake, bang, throw)?
- ☐ Prefer to place toys in mouth rather than play with them?
- ☐ Seem overly sensitive to light?
- ☐ Stare at lights, window blinds or windows?
- ☐ Have difficulty tolerating large crowds or loud noises?

Please explain any checked items from above: _____

_____

_____

What are your biggest concerns regarding your child's self-care, school related and hand skills?

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