

OCCUPATIONAL THERAPY HISTORY FORM

Child's Name _____ Current Age _____

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

- | | |
|---|---|
| <input type="checkbox"/> Dress himself/herself? | <input type="checkbox"/> Snap snaps? |
| <input type="checkbox"/> Button buttons? | <input type="checkbox"/> Start and zip zippers? |
| <input type="checkbox"/> Put on their socks? | <input type="checkbox"/> Tie their shoes? |
| <input type="checkbox"/> Manage their pants during toileting? | <input type="checkbox"/> Brush their teeth? |
| <input type="checkbox"/> Brush/comb their hair? | <input type="checkbox"/> 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?
