Bird Kern and Dalmia

Speech/Language Pathologists & Occupational Therapists
1101 So. Winchester Blvd. E155, San Jose, CA 95128
www.birdkernanddalmia.com
admin@birdkerndalmia.com

Phone: 408/379-0245 Fax: 408/379-0361

OCCUPATIONAL THERAPY CASE HISTORY

General Information:

Client Name: _____

Date of Birth: _____ Age: _____

Mother's Name: _____ Phone Number: _____

Address: _____ E-

Mail: _____

Mother's Employer: _____

Father's Name: _____ Phone Number: _____

Address: _____ E-

Mail: _____

Father's Employer: _____

Pediatrician: _____ Phone Number: _____

Medical History:

Does your child have a diagnosis given by another professional? ■ Yes ☐ No

Diagnosis: _____

Pregnancy Duration: _____ Delivery: ☐ Vaginal ☐ C-Section ☐ Breech

Complications: ☐ Yes ☐ No If yes, please explain:

_____

_____

Number of Ear Infections: _____ Treatment: _____

Current Medications: _____

Known Allergies: _____

Special Diet: _____ Surgeries? _____

Is your child currently receiving any of the following services?

☐ OT ☐ PT ☐ Speech ☐ Psychologist ☐ Behaviorist ☐ Nutritionist ☐ Other

If yes, please list provider: _____

_____

Developmental History:

Please list the approximate age your child did the following:

_____ roll front to back _____ roll back to front _____ sit unsupported _____ crawl

_____ pull to stand _____ cruise furniture _____ walk unassisted _____ run

_____ hold cup or bottle _____ finger feed _____ use fork or spoon

_____ dress self _____ tie shoes _____ toilet trained

Please list any over or under sensitivity you notice in the following areas:

Tactile (clothes, teeth/hair brushing, sand play, food, etc.): _____

_____

_____

Visual (doesn't notice things, easily distracted, overwhelmed by crowds, etc.): _____

_____

_____

Auditory (things are too loud, makes excessive noise, etc.): _____

_____

_____

Vestibular (always moving, gets car sick, fearful of swings/slides, etc.) _____

_____

_____

Proprioceptive (clumsy, runs into things/people, rough play, etc.): _____

_____

_____

Internal sensation (hunger, thirst, cold, etc.): _____

_____

_____

School History:

Current School: _____ Grade: _____

Does your child receive special instruction or have an IEP? ☐ Yes ☐ No

If yes, what areas do they receive support in? _____

_____

Has your child's teacher expressed concerns about academic performance? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Leisure History:

Does your child play any sports? _____

_____

What activities does your child enjoy? _____

_____

What activities does your child avoid? _____

_____

Additional Information:

Is there anything else you would like us to know about your child? _____

_____

_____

_____

_____

Person filling out this form: _____

Relationship to client: _____ Date: _____