Authentic Health LLC

Developmental and Medical History for Occupational Therapy Clients

Child Name: _____ Date of Birth: _____

Nickname: _____

Address: _____

Language/s Spoken: _____

Parent/Guardian: _____

Address: _____

Contact Phone: _____ Email: _____

Other Parent/Guardian: _____

Address: _____

Contact Phone: _____ Email: _____

Siblings Names and Ages: _____

_____

Any History of Difficulties with others in family? Yes No Please Explain: _____

_____

_____

Birth History: Normal Induced C-Section Apgar Scores: _____

Special Precautions During Pregnancy? _____

Any Significant Medical History? Hearing Vision Physical Challenges Surgery/ies

Current Diagnosis, if any: _____

Allergies or Medications? _____

_____

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Circle Any that Apply:

Frequent ear infections Frequent colds/respiratory issues Seizures

Sensory Defensiveness: Touch Vision Hearing Movement Taste Smell Clumsy

Sensory Seeking: Pressure (crashing/banging) Texture (specific foods/clothes/etc.) Movement

Other Professionals Working with Your Child:

Name: _____ Phone: _____

Name: _____ Phone: _____

Developmental History:

Age Your Child:

Rolled Over: _____ Sat Up: _____ Crawled: _____ (belly hands /knees)

Walked: _____ Walked up/down stairs: _____ Jumped: _____

Rode Tricycle: _____ Started Dressing Self: _____ Potty Trained: _____

Circle what your child can do:

Snaps (open and close)	Buttons (open and close)	Zippers (open and close)
Put on shoes	Put on/Take off shirt	Tie Shoes
Finger Feed Self	Drink from Open Cup	Manage spoon/fork well

Any specific Motor or Self- Help Development Concerns? Please Explain:

_____

_____

Speech/Language Skills: (Circle any area that had difficulty)

Babbling Gestures Jargoning (words mixed with babble) Single Words

Two Words Sentences Prepositions or Pronouns Pronunciation/Clarity of speech

Psychological and Neurological Development:

Has your child had assessment in these areas? Yes No Please explain: _____

_____

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Circle Any That Apply: (history or current)

Over active	Sleep Challenges	Bed Wetting	Nightmares
Sensitive to Touch	Sensitive to Sound	Tunes Out	Short Attention
Temper Tantrums	Destructive	Aggressive	Withdrawn
Head Banging	Avoid People	Block Ears/Eyes	Balance Issues
Easily Overwhelmed	Easily Upset	Shy	Sad/Angry
Perseverative Behaviors	Obsessive Thoughts/words	Repetitive Activities	Controlling

Educational Development:

Grade Your Child is in: _____ Teacher: _____

School Attending: _____

Any School Concerns? Yes No Please Explain: _____

Special Services in School? Yes No If Yes: (Circle One) Section 504 IEP Special Support Other

Any Services Received outside of school? Please Explain: _____

_____

Child's Attitude Toward School and Learning: _____

_____

Other:

Has your child received OT services in the past? Yes No Please Explain:

_____

_____

What are you seeking to gain from Authentic Health OT Services? _____

_____

_____

Anything else we should know? _____

_____

_____

_____ _____

Parent/Guardian Signature Date of Signature