Delaware Speech and Hearing Center
COMMUNICATION FOR A LIFETIME

___ 494 W Central Ave; Delaware, OH 43015 ____ 3940 N Hampton Drive; Powell, OH 43065

OCCUPATIONAL THERAPY CASE HISTORY INFORMATION (R) 7/2022

Please complete and bring the enclosed forms, insurance cards, and applicable copay with you at the time of your child's testing. Your appointment is for _____ at _____Please call 740-369-3650 **IN ADVANCE** with any questions or to cancel.

Child's Name: _____ Birthdate: _____ Age: _____

Address: _____ Male Female

City _____ Zip _____ County _____

Parent/Guardian Name: _____ Birthdate: _____Occupation: _____

Address: _____City _____Zip_____

(H) Phone: _____ (W) Phone _____ (Cell) _____

(H) Ok to leave message (W) Ok to leave message (Cell) Ok to leave message

Employer: _____ Email Address: _____

Parent/Guardian Name: _____ Birthdate: _____Occupation: _____

Address: _____City _____Zip_____

(H) Phone: _____ (W) Phone _____ (Cell) _____

□ Ok to leave message □ Ok to leave message □ Ok to leave message

Employer: _____ Email Address: _____

Would you like to receive our newsletter? Y N Electronic Mail

Name(s)/Relationship(s) of People Living At Home: _____

_____Person completing form/relationship_____

Physician/Address: _____

Referred By/Address: _____

Child's School/Daycare/Preschool _____

REASON FOR EVALUATION (please check all that apply)

□Fine Motor □ Sensory □ Mobility □ Gross Motor □ Self Care Skills □ Vision Concerns

□ Overactive □ Under-active □ Difficulty with transitions □ Difficulty following directions

□ Difficulty with self-regulation skills □ Difficulties with attending to tasks

□ Feeding Concerns □ Have aversions to touch, sight, sounds, or smells

□Other _____

MEDICAL HISTORY (Circle one) **(If yes, please explain)**

Were there any problems during pregnancy or difficulties at birth?	NO	YES	_____
Was your child born a month or more early?	NO	YES	_____
Has your child been hospitalized at any time?	NO	YES	_____
Has your child had any trouble with eating, sucking, or swallowing?	NO	YES	_____
Is there a family history of speech/language/hearing problems?	NO	YES	_____
Are there any known educational difficulties?	NO	YES	_____
Does your child have any allergies?	NO	YES	_____
Has your child had his or her tonsils removed?	NO	YES	_____
Has your child had his or her adenoids removed?	NO	YES	_____
Is your child presently taking any medications?	NO	YES	_____
Have a history of ear infections?	NO	YES	How many? ____ Date of last one _____

List any current medical history/ medical diagnosis: _____

DEVELOPMENTAL MILESTONES

What age did you child achieve the following developmental milestones?

Crawl (age in months)_____ Sit Up (age in months)_____ Walk (age in months)_____

Fed Self (age in months)_____ Toileted (age in months)_____ Dress Self (age in months)_____

CURRENT SKILLS

Does your child seem awkward, uncoordinated, or clumsy? □ yes □ no

Does your child lose their balance or fall easily? □ yes □ no

Does your child display a hand preference? □ None □ Left □ Right

Indicate any/all areas of difficulty:

□ Zippers/Buttons □ Hopping/Jumping □ Handwriting □ Lacing/Tying Shoes

□ Impulsivity □ Overly cautious □ Avoids getting messy

□ Throwing ball overhand □ Walking/Running □ Walking up/down stairs

□ Crossing midline □ Copying shapes □ Cutting Balance/Coordination

□ Activity seeking □ Activity avoidance (i.e. swings, slides) □Exhibits toe walking

□ Sensory Preferences/Avoidances (textures, sounds, light) □Follow simple directions ("Shut door" "Get shoes")

□ Using utensils □ Difficulty completing tasks □ Other

Behavioral Characteristics (check all that apply):

□ Cooperative □ Attentive □ Willing to try new activities □ Easily distracted/short attention

□ Plays alone for reasonable length of time □ Destructive/aggressive

□ Separation difficulties □ Withdrawn □ Easily frustrated/impulsive □ Inappropriate behavior

□ Stubborn □ Self-abusive behavior □ Restless □ Lack of appropriate eye contact

Additional information: _____

_____

THERAPY/TREATMENT

My child HAS HAS NOT been in enrolled in therapy/treatment before HAS HAS NOT been evaluated before

When? _____ Where? _____

Comments about previous therapy/treatment _____

Is your child currently receiving any educational support services or other therapeutic services? Circle all that apply

Speech When _____ Where _____

Occupational Therapy When _____ Where _____

Physical Therapy When _____ Where _____

Other _____ When _____ Where _____