SENSABLE kids

Date: _____

Child Name: _____ DOB: _____

Parent Name(s): _____ Occupation: _____

_____ Occupation: _____

Address: _____

CONCERNS/REFERRAL INFORMATION

What are your concerns? What do you hope to gain from this occupational therapy assessment and/or treatment?

Does or has your child received any other evaluations or therapies (OT, SLP, PT, psychologist, nutritionist, etc.)? If so, please include service, name of provider, and the date of the last evaluation.

What are you child's strengths/interests? _____

Please describe your child's developmental challenges and when you first noticed them:

Has your child experienced the death of a family member, close friend, or pet? If so, when?

Has your child witnessed or been the victim of a crime or abuse? If so, when?

Are there any current stresses in the family or the child's life? _____

What do you enjoy most about your child and family? _____

Does your child have any behavioral issues about which you are concerned? If yes, please explain.

What disciplinary techniques have you been using with your child? Do you feel they are effective?

Does your child have any specific fears of which we should be aware?

SCHOOL RELATIONSHIPS

School Name:

Teacher Name: Grade:

Does your child have an IEP or 504 plan?

List concerns your child's teacher/daycare provider have beginning with those of greatest importance:

What solutions have been attempted at home and at school?

FAMILY RELATIONSHIPS

How would you describe your child's general adjustment at home?

Poor Fair Good Excellent

How would you describe your child's relationship with the following family members?

Mother:

Father:

Guardian:

Sibling(s)

Have there been any significant family events in the course of your child's development, such as extended separations, abuses, major moves, divorce, marriage, or birth of siblings?

Is there any family history of developmental delay, learning disability or behavioral disorder?

PRENATAL HISTORY: PREGNANCY

If the child is adopted, please give what information you have in the Adoption History section

Mother's condition during pregnancy included?

_____	In good general health	_____	Physically active
_____	Bleeding	_____	Toxemia
_____	Rubella	_____	Premature contractions
_____	Edema	_____	Cardiac infection
_____	Gestational Diabetes	_____	Convulsions
_____	Anemia	_____	High fever
_____	Confinement to bed	_____	Hypertension (high blood pressure)
_____	Surgery	_____	Excessive nausea
_____	Serious injury	_____	Amniotic fluid loss
_____	Shock	_____	Drank alcohol infrequently
_____	Stress	_____	Drank no alcohol
_____	Accident	_____	Drank alcohol frequently
_____	Loss of loved one	_____	Smoked more than a pack a day
_____	Allergies	_____	Smoked less than a pack a day
_____	Emotional strain	_____	Did not smoke
_____	Prescription Drugs	_____	Illegial Drugs

Is there additional information you'd like to provide?

Hospital and Birthweight:

Indicate the characteristics of the labor and delivery:

_____	No Complications with Delivery		
_____	Full term, 38+ weeks	_____	Premature; # of weeks gestation
_____	Vaginal delivery	_____	Induced labor
_____	C-section emergency	_____	C-section scheduled
_____	Local anesthesia-epidural	_____	Forceps Used
_____	Cord around neck	_____	Suction/vacuum used
_____	Baby cried immediately	_____	Jaundice
_____	Required Intervention	_____	Did not immediately breathe
_____	Poor sucking	_____	Feeding tube
_____	Separation in first days	_____	Positive newborn/mother bonding
_____	Other birth injuries	_____	Required special treatment (i.e. oxygen)

Additional Comments:

PRENATAL HISTORY: ADOPTION

Age when adopted: _____

Prior foster homes: _____

Physical appearance when adopted: _____

Response to new home: _____

Is child aware of her/his adoption? _____

Is child diagnosed with attachment problems? _____

Has child or family had psychological counseling? _____

Additional Comments: _____

CHILDHOOD ILLNESSES AND PROBLEMS Check all conditions that apply to your child and provide details.

Problem	Age	Comments:
Ear Infections (how many?)		
Allergies		
Asthma / Bronchitis		
Skin Problems		
Gastro-intestinal problems		
Seizures / epilepsy		
Sleep problems		

Has your child ever been hospitalized? If so, please explain: _____

Has your child ever had a serious accident/injury? If so, please explain: _____

Is your child currently in good general health? If no, please explain: _____

What medications does your child currently take? _____

Current Specialists (GI, ENT, Neurologist, etc.): _____

MOTOR MILESTONES Please give approximate ages that your child:

_____	Sitting	_____	Standing
_____	Crawled	_____	Walked independently
_____	Spoke first words	_____	Put first words together

Infancy and ToddlerHood Check all conditions that apply to your child and provide details below

Infancy

_____	Information not available	_____	Active and alert
_____	Unable to soothe	_____	Happy and playful, soothed easily
_____	Calmed by infant swings	_____	Nauseated ordisliked infant swings
_____	Colic or fussiness	_____	Inactive, reduced exploration of body
_____	Disliked position changes	_____	Had position preference
_____	Disliked lying on back	_____	Disliked lying on stomach
_____	Feeding problems	_____	Disliked certain foods/textures
_____	Difficulty sucking	_____	Breastfed without difficulty

_____	Refuses most foods	_____	Poor appetite
_____	Transitioned to food easily	_____	Age food introduced
_____	Reflux	_____	Spit up frequently
_____	Regular Sleep Patterns	_____	Extended separations (over three days)
_____	Does not want to be held	_____	Wants to be held most of the time

Additional Comments: _____

Toddlerhood

_____	Calmed by car rides	_____	Nauseated by car rides
_____	Extremely active	_____	Inactive, quiet but alert
_____	Difficult to comfort	_____	Reaches to be picked up
_____	Difficulty falling asleep	_____	Excessive sleeper
_____	Physically active during sleep	_____	Sleeps little but seems confortable
_____	Difficult to awaken	_____	Needs a parents presence to fall asleep
_____	Sleep walker	_____	Wanders from table when eating
_____	Toe walked until what age	_____	Went through "Terrible Twos"
_____	Calm	_____	Fearful
_____	Sociable	_____	Happy
_____	Affectionate	_____	Withdrawn
_____	Good eater	_____	Picky Eater
_____	Limited repertoire of play	_____	Difficulty with transitions

Additional Comments: _____

GROSS AND FINE MOTOR SKILLS Check all conditions that apply to your child and provide details

_____ Is able to walk independently
_____ Is able to run independently
_____ Appears stiff, awkward, or clumsy in movement
_____ Seems to have difficulty learning new motor tasks
_____ Seems weaker or tires more easily than peers
_____ Rides a bike/tricycle without training wheels
_____ Difficulty riding a riding toy with feet pushing or propelling
_____ Difficulty learning how to ride a bike without training wheels
_____ Difficulty playing with small manipulative toys
_____ Difficulty catching a ball
_____ Difficulty kicking a ball
_____ Difficulty pumping self on swing
_____ Difficulty learning how to swim
_____ Dislikes coloring or paper/pencil tasks
_____ Dislikes working puzzles, easily frustrated
_____ Difficulty with scissors

Describe your child's sports/physical activity: _____

Describe your child's coordination: _____

MOVEMENT AND BALANCE Check all conditions that apply to your child and provide details

_____ Has trouble or hesitancy in learning to climb/descend stairs
_____ Dislikes being lifted up and gently tossed in the air by parent
_____ Did/does not like being placed on stomach as an infant
_____ Is nauseated/vomits from movement experiences such as swings
_____ Is unable to give adequate warning about nausea
_____ Rocks back and forth when stressed
_____ Hesitates to climb or play on playground equipment
_____ Crawling period absent/very brief
_____ Walks or walked on toes
_____ Gets car sick frequently
_____ Seeks twirling or spinning
_____ Seeks amusement park rides/swings
_____ Is constantly moving or "on the go"
_____ Trips or falls frequently

Additional Comments: _____

_____

_____

AUDITORY AND LANGUAGE Check all conditions that apply to your child and provide details

_____ Has a diagnosed hearing loss
_____ Has or has had repeated ear infections
_____ History of delayed speech development
_____ Stammers or stutters
_____ Often fails to listen or pay attention to what is said to him/her
_____ Does not seem to understand what is said to him/her
_____ Speaks in incomplete sentences
_____ Is afraid of some noises
_____ Seems confused as to the location/direction of sound
_____ Is difficult to understand
_____ Frequently covers ears; is oversensitive to mildly loud sounds
_____ Talks constantly
_____ Particularly distracted by sounds; seems to hear sounds others do not
_____ Has difficulty paying attention in proximity to other noises
_____ Enjoys hearing own voice echo and making loud noises

Has your child been examined by an ear, nose and throat doctor? _____

Physician Name _____ Date of last examination _____

Describe concerns about your child's speech/language: _____

_____

_____

Is there a family history of issues with speech/language? If so, please describe.

_____

_____

If your child does not currently verbalize, how does she/he communicate?

_____

_____

Additional Comments: _____

_____

_____

SOCIAL AND EMOTIONAL BEHAVIOR Check all conditions that apply to your child.

_____ Does not accept changes in routine easily
_____ Becomes easily frustrated
_____ Apt to be impulsive, heedless, and accident prone
_____ Marked mood variations; tendency towards outbursts or tantrums
_____ Tends to withdraw from groups; plays on the outskirts
_____ Frequently breaks toys or is overly rough with toys
_____ Cannot tolerate frustration and acts out
_____ Insists that bedroom/toys must be in order
_____ Seems to do things the hard way
_____ Changes activities frequently
_____ Is impatient and cannot wait
_____ Hums or taps fingers
_____ Does not finish what is started
_____ Takes a long time to settle down
_____ Is generally disorganized
_____ Is unable to put things in order
_____ Cannot play quietly for 20 minutes consecutively
_____ Is difficult to take to visit friends/relatives
_____ Is difficult to leave with a babysitter
_____ Cannot tolerate noisy, busy places
_____ Needs a calm, quiet atmosphere in order to concentrate
_____ Does not seem to learn from experiences
_____ Has no guilt for wrongdoing

_____ Complains of unfair treatment
_____ Is overly concerned about performance
_____ Has poor self image and feels worthless
_____ Is insensitive to others feelings
_____ Has a short fuse and will explode at the slightest irritant
_____ Is overly cautious
_____ Has hurt someone in such a way that medical attention was necessary
_____ Is defiant or belligerent when disciplined
_____ Purposely does the opposite of what is told
_____ Picks only on people smaller than self
_____ Wants friends but is rejected by others
_____ Has few friends and seems disliked by peers
_____ Prefers to play with younger children
_____ Prefers to play with older children
_____ Prefers to play alone
_____ Cannot sit through a board game
_____ Acts without thinking
_____ Runs rather than walks
_____ Cannot keep hands to self
_____ Fidgets or squirms
_____ Does sloppy work in spite of effort
_____ Cannot tell right from wrong
_____ Believes rules apply only to others
_____ Forget social expectations
_____ Always has an excuse
_____ Is irritable
_____ Demonstrates inappropriate sexual behavior (touches self/others, public nudity)
_____ Cries for the slightest reason
_____ Resists authority
_____ Makes up untruths
_____ Cannot be trusted alone
_____ Resists sharing
_____ Has to be the leader
_____ Is physically rough with peers
_____ Is excessively bossy with peers
_____ Is overly submissive, easily led
_____ Gets into fights due to frustration
_____ Appears depressed, sad or gloomy

Additional Comments: _____

_____

_____

SELF CARE

Activity	Unable	Fusses/Dislikes	Assists	Independent
Hand Washing				
Tooth brushing				
Hair brushing				
Showering				
Toilet training				
Wiping				
Bottle				
Sippy cup				
Open cup				
Spoon				
Fork				
Cuts with fork				
Spreads with knife				
Prefers hands				
Shirt on				
Shirt off				
Pants on				
Pants off				
Shoes on				
Shoes off				
Socks on				
Socks off				
Fasteners				
Ties Shoes				
Has chores				
Cooperates with chores				
Rarely helps				
Makes simple sandwich				
Makes bed				

Additional Comments: _____

_____

_____

_____