playSense
PLAY TO LEARN. LEARN TO PLAY.

Background Information and Occupational History

Family Information

Child's Name:	Today's Date:
Birth Date:	Age:

Diagnosis:	Diagnosed by whom?		Date:
Allergies (food, drug, other)			

Address:			
Mother's Name:		DOB:	Occupation:
Office/Cell phone:	Email:	Home phone:	
Father's Name:		DOB:	Occupation:
Office/Cell phone:	Email:	Home phone:	

About your child:

Favorite toys/activities:
Movie/TV characters:

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Movie/TV shows:
Does your child like active/physical play or quiet/sit down play?
Does your child prefer playing in large groups or with 1-2 children?
Does your child enjoy imaginary play? If so, what does he/she like to play?

With whom does the child live most of the time?	☐ Mother ☐ Adoptive parents ☐ Other (Specify):	☐ Father Adopted at what age?	☐ Step parent: ☐ Mother ☐ Father ☐ Grandparents
Siblings: How many?	Name:	Age:	Health:
Use other side for additional information	Name:	Age:	Health:
	Name:	Age:	Health:
	Name:	Age:	Health:
Do you have concerns with any of your other children?			

Emergency contact:	Address:
Phone:	

Referring information:

Whom may we thank for referring your child for an evaluation?	

Reason for referral:	
When did you first have those concerns?	
What do you see as your child's strengths?	
In one sentence, how would you describe your child?	
Do you have any additional information that will help to better understand your child?	
What are your primary goals regarding this evaluation?	

School History:

Hand preference:	Current school placement:
Present grade:	Have any grades been repeated:
Is your child in a special class (specify)?	
What does the teacher say about your child?	

Intervention History: Please include name and contact information if possible.

Current Therapy	Agency/Therapist	Times per week for ___ minutes per session	Evaluations available for review?
Occupational Therapy			
Physical Therapy			

Speech/Language Therapy			
Psychologist			
Behavioral Therapy			
Educational/IEP/IFSP			
Vision Therapy			
Auditory Therapy			
Others (list):			

Pediatrician: Phone:	Address:	
Orthopedist Phone:	Address	
Neurologist: Phone:	Address:	
Last physical examination:	Date:	By whom?
Send repot to which physician(s)?		
Regional Center counselor:		Send reports to counselor? Yes___ No___
Who is financially responsible for this child?		
Release of information signature: Signature_____ Date:_____		
(signature authorizes releases of medical records to physician and/or Regional Center counselor indicated above)		

Please complete *if different* than Current Therapy History

Prior Therapy History	Agency/Therapist	Times per week for ___ mintues per session	Evaluations available for review?
Occupational Therapy			
Physical Therapy			
Speech/Language Therapy			
Psychologist			
Behavioral therapy			
Educational/IEP/IFSP			
Vision Therapy			
Auditory Therapy			
Others (list):			

Medical History

Any difficulties during pregnancy or delivery?	(specify)		
Length of pregnancy:		Length of labor:	
Birth was: Normal ☐ Caesarian ☐ Breech ☐ Multiples ☐			
Birth weight:	Did baby require assistance in starting to breathe? Yes ☐ No ☐		
Remarks:			
Were there any complications/problems in early infancy?	Yes ☐ No ☐	Specify if Yes:	
Were there feeding difficulties in early infancy?	Yes ☐ No ☐	Specify if Yes:	

Respiratory, lung or bronchial difficulties?		Cardiac problems?	
Seizures (when and how often)			
Ear infections? Tubes?	Yes ☐ No☐	Tubes?	
Does your child use any specialized equipment?	Yes ☐ No☐	Explain:	
Previously tried medications?			

Does your child have now or in the past had significant health problems/serious illness/injuries/hospitalizations/surgeries:	
Date:	

X-rays/diagnostic tests/genetic screens (EEG's, Cat scan, MRI, etc.):	
Date:	Diagnostic test and result:

Developmental History:

Children sometimes act or appear younger than their chronological age. What age do you think best describes your child and why?

_____
_____
_____
_____

List the age at which your child accomplished each activity. Indicate "not yet" if they have not yet accomplished it.

Motor:

Head control:	Reaching for objects:
Roll over both ways:	Finger feeding:
Sitting alone:	Pulling to stand:
Creeping on all 4's:	Drawing a circle:
Eating with spoon:	Cutting with scissors:

Walking:	Drink from a cup:
Jumping:	Hopping:
Hopping on one-foot:	Riding a bike:
Does your child have difficulty learning new motor skills?	

Language:

Said first word:	Pointed to simple pictures:
Combined words:	Followed one-step commands:
Spoke sentences:	Followed several-step commands:
Looked when called:	Looked in direction that others point:

Self-help Skills:

Dressing	**Grooming**
Put on shirt independently:	Bathing independently:
Button independently:	Combs hair:
Zips independently:	Toilet trained: bowel_____ bladder _____
Snaps independently:	Toileting independently:
Removes socks and shoes:	
Puts on socks and shoes:	
Ties shoes:	
Pulls up/pushes down pants indep:	

Eating/Feeding:

Does your child eat a healthy variety of foods?
Does your child eat a variety of textures and flavors?
Does your child easily participate in family meals?
Comments, questions or concerns related to eating?

Please check the column which best describes you child. Please include additional remarks that may be helpful including your child's strengths.

Describe your child ***as an infant***:	**Yes**	**No**	**Sometimes**
1. Cried a lot, fussy, irritable			
2. Was good, non-demanding			
3. Was alert			
Describe your child ***as an infant***:	**Yes**	**No**	**Sometimes**
4. Was quiet			
5. Was passive			
6. Was active			
7. Liked being held			
8. Resisted being held			
9. Was floppy when held			
10. Was tense when held			
11. Had good sleep patterns			
12. Had irregular sleep patterns			
Comments:			

Describe your child ***at present***:	**Yes**	**No**	**Sometimes**
1. Is mostly quiet			
2. Is overly active			
3. Tires easily			
4. Talks constantly			
5. Impulsive			
6. Is restless			
7. Is stubborn			
8. Is resistant to change			
9. Over reacts			
10. Fights frequently			
11. Is usually happy			
12. Exhibits frequent temper tantrums			
13. Is clumsy			
14. Has difficulty separating from primary caretaker			
15. Has nervous habits or tics			

16. Falls often			
Describe your child ***at present***:	**Yes**	**No**	**Sometimes**
17. Wets bed			
18. Has poor attention span			
19. Is frustrated easily			
20. Has unusual fears			
21. Rocks self frequently			
22. Has difficulty learning new tasks (i.e. writing, throwing a ball, riding a bike, etc.)			
Comments:			

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