KidSense Therapy Group
209 Cherry Street
Milford, CT 06460
(203) 874-5437

Client's Case History Form- OT/PT

General Information:

Child's Name _____ Date of Birth _____/____/_____

Address_____ Home Phone (___) _____-_____

City _____ State_____ Zip Code_____

Parent/Guardian Name _____Occupation_____

Parent/Guardian Name_____Occupation_____

Where/Who does child live with_____

Pediatrician's Name_____ Phone Number (___) _____-_____

Pediatrician's Address_____

Referred by _____ Reason for Referral_____

Parent's Contact Information
Cell Phone (___) _____-_____ E-mail Address_____

Siblings (Names and Ages)_____

What is the primary language used at home_____

Does child speak/understand any other language _____

Described primary concerns/Reason for seeking therapy _____
_____
_____

Does your child have a diagnosis (i.e. birth defect, genetic disorder, developmental delay)? _____

Child's History

Prenatal and Birth History

Length of Pregnancy_____ Length of Labor_____

General Condition of Mother during Pregnancy _____

General Condition of Mother during Labor _____

Type of Delivery _____ Birth Weight _____
General Condition of Child during/after delivery _____
_____

Please add any information related to the pregnancy/labor/birth than may be pertinent to your child's therapy._____
_____
_____

Medical History

Does your child have a diagnosis? If yes, please explain_____
_____

Has your child had any surgeries/accidents/hospitalizations? If so, what type and when?

Does your child exhibit any of the following illnesses or conditions? Circle and please explain.

Allergies Ear Infections Asthma Seizures Other
_____
_____

Is your child currently taking any medications? If so please explain? _____
_____

Is your child currently seeing any other professional/ physician? If so, please list name and reason? _____
_____
_____

Has your child received any therapy in the past? If so which therapy, where and please give a brief summary of results? _____
_____
_____
_____

Developmental History

Provide the approximate time (in months/years) at which your child began to perform the following activities.

Rolling over_____ Sitting_____ Crawling_____ Walking_____

Using Words (single)_____ (combine words)_____ Feeding Self_____

Does your child have any feeding difficulties currently?_____ In the past?_____

If so, please describe _____

Is your child toilet trained? (daytime)_____ (night time)_____

Do you have any concerns with your child's ability with self care such as dressing, feeding self, grooming, or bath time? _____
_____
_____

Do you have any concerns regarding your child's gross or fine motor skills? For example, walking, running, playing on playground or coloring, using toys, fasteners.
_____
_____
_____

Educational History

Where does your child currently attend school? _____
Teacher _____ Grade_____

Does your child exhibit any academic difficulties? _____
_____

Does your child receive any services in school? _____

Does your child have an Individualized Educational Plan (IEP) for school? If so, please briefly explain goals and objects that it addresses._____
_____
_____

How does your child interact with peers? _____
How does your child interact with adults? _____

Do you feel your child exhibits any sensory processing issues? If so, please comment.
_____
_____
_____

What are your goals/expectations for therapy? _____
_____
_____

Person Completing Form _____ Relationship to Child _____

Signature_____ Date_____