Leaps and Bounds
Pediatric Occupational Therapy

Background Information

Medical Information

Has your child received previous evaluations and/or treatment by an occupational therapist? ___

If yes, when and where? _____

Has your child had a vision test? _____ If yes, when and where?

Has your child had a hearing test? _____ If yes, when and where?

What were the results of the test(s)? _____

_____

Has your child ever worked with a nutritionist? _____ If yes, what were the results? _____

_____

Does your child have any food allergies or sensitivities? _____ If yes, what are they? _____

_____

Has your child had any of the following? If yes, describe and give approximate dates and frequency.

Congenital Abnormalities: _____

Surgery: _____

Serious Injury: _____

Casts or Braces: _____

Ear Infections: _____

Tubes in Ears: _____

Allergies: _____

Seizures: _____

Other: _____

List any medications your child is currently receiving and frequency of dosages:

_____

_____

Mother's Health During Pregnancy

Did the mother:

1. Have any infections/illnesses during pregnancy? If so, please describe: _____

   _____

2. Have any shocks or unusual stress during pregnancy? If so, please describe: _____

   _____

3. Receive any medication during pregnancy? If so, please describe: _____

   _____

4. Have any complications during delivery/labor? If so, please describe: _____

   _____

Child's Birth

1. Was your child full term?_____
2. Was your child born premature? _____ If so, number of weeks? _____
3. Child's weight at birth: _____
4. Was your child small for gestational age? _____
5. Was your child breech (feet first)? _____
6. Did your child require forceps for delivery? _____
7. Did your child require suction for delivery? _____
8. Did your child require intensive-care hospitalization? _____

Infancy and Early Childhood

Does or did your child:

1. have feeding problems? _____ If yes, describe: _____

   _____

2. have sleeping problems? _____ If yes, describe: _____

   _____

3. dislike lying on stomach? _____
4. dislike lying on back? _____
5. enjoy bouncing? _____
6. become calmed by car rides or infant swings? _____
7. become nauseated by car rides or infant swings? _____

Developmental Milestones

Please give approximate ages that your child (please indicate if a specific milestone was not achieved):

Rolled over: _____ Sat alone: _____ Crawled: _____

Walked: _____ Chewed solid food: _____ Drank from a cup:_____

Said words: _____ Said sentences: _____

Does or did your child hesitate/show delays in learning how to go up stairs? _____

Does your child alternate feet? _____
Does your child hold the railing or wall? _____

Does or did your child hesitate/show delays in learning how to go down stairs? _____

Does your child alternate feet? _____
Does your child hold the railing or wall? _____