Lucile Packard Children's Hospital at Stanford
Rehabilitation Services Department
Occupational and Physical Therapy

Case History Form

BACKGROUND INFORMATION

Child's name:_____ DOB: _____

Describe your child's difficulties: _____

What other factors do you feel may be causing or contributing to your child's difficulties?
_____

What questions do you want to have addressed as part of the evaluation?
_____

PREGNANCY, BIRTH AND DEVELOPMENTAL HISTORY

Were there complications during pregnancy or birth? _____
If yes, please explain: _____

Was your child born prematurely? ___YES ____NO
If yes, by how many weeks? _____

Please indicate the age which your child achieved the skills listed below.

_____ Sitting alone
_____ Crawling
_____ Walking alone
_____ First baby foods
_____ Drink from cup alone
_____ Said first word
_____ Undress self
_____ Dress self with help
_____ Potty trained

MEDICAL HISTORY

Is your child under medical treatment or on medication? ____YES ____NO
If yes, please list the medications and the reasons for them_____
_____

Past hospitalizations/surgeries _____
Does your child see other medical specialists? ___YES ___NO
If yes, please list the reasons for them:_____

Does your child have, or has he/she had any of the following conditions (please check):

___Visual Difficulty
___Allergies
___Impetigo
___Chicken Pox
___Meningitis
___Hearing Difficulty
___Seizures
___Measles
___Cleft Palate
___Other (not listed): _____
___Ear Infections
___Encephalitis
___Mumps
___Head injury

EDUCATIONAL HISTORY

Daytime caregiver(s) for child
___ Parent ___ Family member ___ Nanny
___ Babysitter ___ Daycare program ___ Other_____

Current grade level:_____

Please describe your child's level of performance at school: _____
_____

Is there anything related to your child's behavior that is important for the clinician to know? _____

List, if any, after school activities your child participates in: _____

Does your child currently participate in any therapies (Speech, OT, PT)? _____
If yes, please list:
Type of therapy _____ How often_____ Reason for therapy_____
_____

SUMMARY
Please list any other information not addressed above: _____
_____
_____

Name of person completing this form: _____
Relationship to child _____
Preferred daytime number: _____
Date completed: _____