6520 3rd Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

Occupational Therapy
Case History Form

Child's Name:_____ Date of Birth_____

Father's Name:_____ Cell Phone_____

Mother's Name:_____ Cell Phone_____

Home Address:_____

City_____ State_____ Zip_____

Child resides with:_____

Father's email address:_____

Mother's email address:_____

I do wish to allow email communication _____

I DO NOT wish to allow email communication_____

Child's School_____ Grade_____ Teacher_____

Insurance Information

Insured's Name (if different from patient)_____

Relationship to patient:_____ Date of birth_____

Insurance:_____

Group#_____ ID or SS#_____

Insurance Phone_____

Referred by_____

Doctor's Name_____

Dr. Address:_____ Phone_____

Family History:

Siblings:_____ Age:_____

_____ Age:_____

_____ Age:_____

6520 3rd Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

Is there a family history of : (Yes/No)

Speech/Language Difficulties _____

Hearing Impairment/Deafness_____

Learning Difficulties_____

If you responded "yes" to any of the above, please describe:_____

_____

_____

Is there a language other than English spoken in the home? _____Yes _____No

If yes, which language?_____

Does the child speak this language? _____Yes _____No

Which language does the child prefer to speak at home?_____ School?_____

Birth and Medical History

Was there anything unusual about the pregnancy or birth?_____Yes _____No

If yes, please explain_____

How old was the mother when the child was born? _____

How many months was the pregnancy? _____

Was the mother sick during pregnancy? _____

Birth weight?_____

Has your child had any of the following:

Adenoidectomy _____ High Fevers_____ Allergies_____

Head injury_____ Breathing Difficulties_____ Sleeping difficulties _____

Chicken Pox_____ Thumb/Finger Sucking _____ Frequent Colds _____

Tonsillectomy_____ Frequent Ear Infections_____ Tonsillitis _____

Ear (PE) Tubes _____ Vision Problems_____

If you checked any, please provide details/dates:_____

_____

6520 3rd Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

Other serious illness/injury:_____

Date of last hearing screening:_____ Results:_____

Date of last vision screening:_____ Results:_____

Hospitalizations:_____

Medications:_____

Developmental History

Please tell the approximate age your child reached the following milestones:

_____Sat Alone _____ Grasped crayon/pencil _____Babbled

_____Crawled _____ Said first word (s) _____Put two words together

_____ Spoke in short sentences _____Walked

_____ Completed toilet training

Oral Motor & Feeding History:

Has your child experienced feeding/eating difficulties (e.g. biting, swallowing, chewing)? Yes/No _____

If yes, please explain:_____

Was your child breast-fed or bottle-fed?_____

Does your child eat by self using utensils? Yes/No_____ Drool?_____

Does your child put toys in mouth? Yes/No _____

If yes, please explain:_____

Does your child have food allergies? Yes/No _____

If yes, please explain:_____

Does your child have food preferences/aversions? Yes/No_____

If yes, please explain:_____

Speech & Language Development:

How does your child prefer to communicate?

_____ gestures _____ words _____both _____neither

Number of words in a typical sentence? _____

6520 3rd Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

School History

Has your child ever repeated a grade?_____ If so, what grade?_____

What are your child's strengths and/or best subjects?_____

Is your child having difficulty with a particular subject? Yes/No _____ Subject_____

Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)?

Yes/No _____ If yes, please explain_____

Favorite Activities

Please list your child's favorite activities, hobbies, toys, games, etc._____

_____

6520 3rd Street Rockledge, FL 32955 P (321) 622-8792 F (321) 622-8793

PLEASE READ AND SIGN THE FOLLOWING

I give permission for Taylor Made Therapies, LLC and contracted therapists to evaluate and treat my child.

Signature_____ Date_____

I have reviewed and received Taylor Made Therapies, LLC's HIPAA Policy Statement.

Signature_____ Date_____

I authorize release of any medical or other information necessary to process this claim, including release of information to my Primary Care Physician as designated above and directly to the insurance company. I authorize payment of medical benefits to Speech Path of Brevard, LLC for services provided. I request and assign benefits to Taylor Made Therapies, LLC for all insurance benefits otherwise payable to me for services rendered.

Signature_____ Date_____

I authorize discussion of my case with the following specific individuals:

_____

_____

_____

_____

_____

Signature_____ Date_____