



6520 3<sup>rd</sup> 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 consent to receiving email communication      Yes      No

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 3<sup>rd</sup> 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             | Chicken Pox             |
| Head injury          | Breathing Difficulties | Sleeping difficulties | Frequent Ear Infections |
| Thumb/Finger Sucking | Frequent Colds         | Tonsillectomy         |                         |
| Tonsillitis          | Ear (PE) Tubes         | Vision Problems       |                         |

If you checked any, please provide details/dates: \_\_\_\_\_

\_\_\_\_\_



6520 3<sup>rd</sup> 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 3<sup>rd</sup> 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 3<sup>rd</sup> 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 \_\_\_\_\_