OCCUPATIONAL THERAPY SENSORY MOTOR HISTORY FORM

Child's Name: _____

Birth Date: _____Age:_____ Sex: _____

Is child adopted? ☐ Foster child? ☐ If yes, at what age? _____

Mother's Name: _____
Address: _____ Phone: _____
Email: _____
Occupation: _____

Father's Name: _____
Address: _____ Phone: _____

Occupation: _____

Marital Status (Please check): ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Parent completing this questionnaire: ☐ Mother ☐ Father

FAMILY HISTORY

Names of brother(s)/sister(s) Age Sex Grade in School

_____
_____
_____
_____

Do these brother(s)/sister(s) live with child? ☐ Yes ☐ No

With whom/who does the child spend most of his day?_____

Name of others closely involved with child:
How does your child choose to use his/her free time?

Does your child play appropriately with toys? ☐ Yes ☐ No
If no, explain

MEDICAL HISTORY

Pediatrician/Family Doctor _____
Address _____Phone _____

Pregnancy: ☐ Full Term ☐ Premature

Mother's general health during pregnancy: ☐ Good ☐ Fair ☐ Poor

Problems encountered during pregnancy (illnesses, injuries, stress, bleeding, fainting spells, anemia, etc.):
_____
_____

Labor: Length of total labor: _____Difficult labor? ☐ Yes ☐ No

Problems encountered during labor: _____

Delivery: _____
Complications: ☐ Induced Birth ☐ Breech Presentation

Length of hospitalization: _____

Birth: Child's birth weight _____lbs. _____ oz.

Complications: ☐ Jaundice ☐ Cyanosis ☐ Congenital defects
Was there a need for: ☐ Oxygen ☐ Transfusions ☐ Tube Feedings

If so, please explain _____

Were there any feeding difficulties? ☐ Yes ☐ No
Explain _____

Are there feeding problems now? ☐ Yes ☐ No
Explain _____

Child's general health at present: ☐ Good ☐ Fair ☐ Poor

Any present medications? ☐ Yes ☐ No
If yes, type for _____
Any physical handicaps? ☐ Yes ☐ No
If yes, describe: _____

Any allergies: ☐ Yes ☐ No
If yes, type _____

Any ear infections? ☐ Yes ☐ No
If yes, frequency _____
Tubes? ☐ Yes ☐ No
When _____

Has your child ever been diagnosed as having any medical or psychological/educational conditions?
_____ If yes, please explain _____
_____

Who made the diagnosis and when? _____

Describe any precautions regarding your child's care _____
_____

DEVELOPMENTAL HISTORY

Please check if your child has ever had any of the following issues. If checked, please note dates and describe below:

Colic	Strep throat	Food intolerances	Allergies
Seizures	Reflux	Operations	Skin sensitivity
Bronchitis	Asthma	Vision problems	Eczema
High fevers	Measles	Pneumonia	Unconsciousness
Black outs	Vomiting	Physical injuries	Diabetes
Staring spells	Hearing problems	Sinus infections	Lead poisoning
Motion sickness	Ear infections	Lung difficulty	

_____
_____
_____

Check which of the following describes your child **as an infant:**

☐ Fussy ☐ Irritable ☐ Good ☐ Non-demanding ☐ Quiet ☐ Passive ☐ Active

☐ Liked being held ☐ Resisted being held ☐ Floppy when held

☐ Tense muscles when being held ☐ Good sleep patterns ☐ Irregular sleep patterns

☐ Over-active, never still unless sleeping

Comments: _____
_____
_____
_____

Check which describes child **at present**:

☐ Usually happy ☐ Mostly quiet ☐ Overly active ☐ Tires easily ☐ Talks constantly
☐ Too impulsive ☐ Restless ☐ Stubborn ☐ Resistant to changes ☐ Over reacts
☐ Clumsy ☐ Wets bed ☐ Fights frequently ☐ Exhibits frequent temper tantrums
☐ Has difficulty separating from primary caretakers ☐ Has nervous habits or tics
☐ Falls often ☐ Poor attention span ☐ Easily frustrated ☐ Cries often
☐ Cries infrequently ☐ Rocks self frequently ☐ Has difficulty learning new task
Comments: _____
_____
_____
_____

Give approximate ages at which child did the following **routinely**:

Held up head (while on stomach) _____
Belly crawled _____
Crawled on hands and knees _____
Sat alone _____
Pulled to standing _____
Stood alone _____
Walked _____

General impression of child's motor development:
Gross Motor: ☐ Slow ☐ Normal ☐ Advanced
Fine Motor: ☐ Slow ☐ Normal ☐ Advanced
Poor Handwriting: ☐ Yes ☐ No

Self-Care:
Bottle fed: ☐ Yes ☐ No Type of Formula _____
Nursed: ☐ Yes ☐ No If yes, explain _____
Currently eats: ☐ Breast Milk ☐ Formula ☐ Baby Food ☐ Junior Foods
☐ Mashed Table Foods ☐ Table Foods
Objects to certain foods (texture, taste, etc.) _____

Describe degree to which child routinely performs the following:
Feeds self: ☐ All ☐ Most ☐ Some ☐ Rare
If feeds self, uses: ☐ Bottle ☐ Fingers ☐ Spoon ☐ Fork
Bathes self: ☐ All ☐ Most ☐ Some ☐ None
Undresses self: ☐ All ☐ Most ☐ Some ☐ None
Dresses self: ☐ All ☐ Most ☐ Some ☐ None

Does your child:

Use a spoon correctly ☐ Use a fork correctly ☐ Use a knife correctly ☐

Can your child

Fasten buttons ☐ snaps ☐ zipper ☐ belt ☐ tie shoes ☐

Can your child

Jump with 2 feet ☐ stand on 1 foot ☐ gallop ☐ pump a swing ☐ ride a tricycle ☐

Ride a bike ☐ walk up stairs alternating feet ☐ walk downstairs alternating feet ☐

Catch a ball ☐ kick a ball ☐ throw a ball overhand ☐

Is child toilet trained? ☐ Yes ☐ No ☐

If yes, at what age? _____

Has child achieved skills and then lost them? ☐ Yes ☐ No

If so, what and when _____

SENSORY HISTORY

Vestibular (movement and gravity information). Check which of the following apply to your child:

☐ Rocks while sitting ☐ Jumps a lot ☐ Likes being tossed in the air ☐ Good balance

☐ Fearful of heights ☐ Fearful of movement ☐ Likes Merry-Go-Rounds

☐ Spin & Whirl more than other children ☐ Gets car sick

☐ Enjoys being rocked: ☐ Now ☐ As an infant

☐ Prefers quiet play as opposed to more active play

☐ No fear of movement or falling

Comments: _____

_____

_____

_____

Tactile (touch information): Check which of the following apply to your child:

☐ Avoids "messy" things (mud, finger paint, etc.) ☐ Dislikes having face washed or wiped

☐ Irritated by cloth of certain textures ☐ Objects to being touched

☐ Dislikes unexpected touch ☐ Avoids using hands for extended periods

☐ Bangs head on purpose (now or in the past) ☐ Pinch, bite, or otherwise hurt him or herself

☐ Examines objects by putting them into mouth ☐ Tends to feel pain less than others

☐ Isolates him or herself from other children ☐ Strong likes or dislikes toward food textures

☐ Excessively ticklish ☐ Dislikes hair washing ☐ Dislikes nail cutting
☐ Wants to handle everything ☐ Seeks lots of touch

Comments: _____
_____
_____
_____

Proprioceptive (muscle and joint information): Check which of the following apply:

☐ Hold his hands in strange positions ☐ Hold body in strange positions
☐ Good coordination with small things (i.e., pencil, buttons)
☐ Walks on toes (or did when younger)
☐ Went from sitting to standing with little or no crawling
☐ Crept on tummy rather than hands or knees
☐ Leaps from one position to the next, unable to move slowly from one to another

Auditory: Check which of the following apply to your child:

☐ Responds negatively to unexpected or loud noise
☐ Has difficulty paying attention when there are other noises nearby
☐ Misses hearing some sounds
☐ Seems confused as to the direction of sounds
☐ Seems to enjoy strange noises and/or make loud noises
☐ Appears to be hard of hearing ☐ Enjoys music
☐ Has a diagnosed hearing loss ☐ Wears a hearing aid

Comments: _____
_____

Visual: Check which of the following apply to your child:

☐ Reversals in copying ☐ Happier in the dark ☐ Looks very closely and carefully at pictures or object ☐ Has difficulty discriminating shapes or colors ☐ Resists having eyes covered
☐ Becomes very excited when there is a variety of visual objects
☐ Squints often ☐ Has difficulty visually focusing on things far away
☐ Has difficulty focusing on things close ☐ Wears glasses
☐ Has difficulty maintaining eye contact with another person
☐ Difficulty following an object across the room

☐ Difficulty following an object tossed toward him/her

☐ Sometimes shakes head in awkward manner

☐ Shifts head to one side in order to look at an object

Comments: _____
_____
_____

Gustatory-Olfactory (taste and smell information) Check which of the following apply to your child:

☐ Acts as though all food tastes the same ☐ Chew on non-food objects

☐ Has unusual cravings for certain foods ☐ Dislikes food of certain textures

☐ Explores by smelling ☐ Discriminates odors ☐ Reacts negatively to smell

☐ Ignores unpleasant odors

Comments: _____
_____
_____

SCHOOL INFORMATION

School: _____Grade: _____

School Days: ☐ Part day _____ a.m. to _____ p.m . ☐ All day

Has child been in a special classroom and/or attended any remedial classes? ☐ Yes ☐ No
If yes, describe what type, where, when? _____

Have you or the teacher observed that your child is (check all that apply):

☐ Noticeably distracted in class?

☐ Functions better in a one-to-one relationship than in classroom situations?

☐ Has to be reminded how to hold his pencil/paper when writing?

☐ Need to prop his head in her/his hand while reading or writing at the desk?

☐ Shows a hand preference? (which) _____

Which hand does he/she prefer for feeding? _____Crayon or pencil _____
Throwing _____Pointing _____Cutting
_____

If he/she prefers the left hand are there other left handers in the family? _____

☐ Confused in right-left discrimination tasks? (describe) _____

☐ A poor speller? _____ _ ☐ Good at making friends easily? _____

☐ Tending to prefer to play with younger children? _____

☐ Tending to prefer the company of adults? _____

What academic skills are the hardest? _____

_____