Sparrow

Medical History and Subjective Information Form
Occupational Therapy

Please answer the following questions. If you need help filling out this form, we would be happy to assist you.

Patient Name_____ Birth Date: _____ Today's Date: _____

Past Medical History

☐ None

Neurology
- ☐ Hydrocephalus
- ☐ Cerebral Palsy
- ☐ Seizure Disorder
- ☐ Cerebral Vascular Accident
- ☐ Traumatic Brain Injury
- ☐ Arteriovenous Malformation
- ☐ Other:_____

Genetics
- ☐ Down Syndrome
- ☐ Osteogenesis Imperfecta
- ☐ Arthrogryposis
- ☐ Dystrophy
- ☐ Angelman Syndrome
- ☐ Neurofibromatosis
- ☐ Other:_____

Psychiatric
- ☐ ADHD
- ☐ Obsessive Compulsive Disorder
- ☐ Bipolar
- ☐ Opposition Defiance Disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Other:_____

Cardiac
- ☐ Atrial Septal Defect
- ☐ Ventricular Septal Defect
- ☐ Patent Ductus Arteriosis
- ☐ Mitrovalve Prolapse
- ☐ Enlarged Ventricle
- ☐ Tetralogy Of Fallot
- ☐ Other:_____

Hemocology/Oncology
- ☐ Sickle Cell Anemia
- ☐ Tumor
- ☐ Leukemia
- ☐ Hemophilia
- ☐ Acute Lymphoblastic Leukemia
- ☐ Cancer of Blood
- ☐ Other: _____

Miscellaneous
- ☐ Obesity
- ☐ Failure to Thrive
- ☐ Fetal Alcohol Syndrome
- ☐ Learning Disability
- ☐ Cognitive Impairment
- ☐ Trauma
- ☐ Other:_____

Physicians Currently Active in your Child's Care:

Name/Date	Name/Date
Family Doctor:	Psychologist:
Physiatrist:	Physical Therapist:
Orthopedist:	Occupational Therapist:
Neurologist:	Speech Therapist:
Orthotist:	Other:

Diagnostic Test: Has your child had any of the following?

Test	Date/Result	Test	Date/Result
X-ray		EMG	
CT Scan		Hearing	
MRI		Vision	
EEG		Other:	

Please Check all of the following boxes that apply:
- ☐ 1 story house with/without basement
- ☐ 2 story house with/without basement
- ☐ Apartment
- ☐ Mobile Home
- ☐ Stairs to enter home/apartment
- ☐ Railing on stairs ___1 ___2
- ☐ Walk-in shower
- ☐ Tub/Shower Combination

Child Lives with: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Foster Parents ☐ Aunt ☐ Uncle ☐ Brother(s) # __
☐ Sister(s) # __ ☐ Step-mother ☐ Step-father ☐ In Residential Facility ☐ Other _____

Previous Therapy:	Yes	No		Yes	No
Early-On Physical Therapy	☐	☐	Aquatic Therapy	☐	☐
Early-On Occupational Therapy	☐	☐	Music Therapy	☐	☐
Early-On Speech Therapy	☐	☐	ABA Therapy	☐	☐
School Physical Therapy	☐	☐	Floortime	☐	☐
School Occupational Therapy	☐	☐	Behavioral Therapy	☐	☐
School Speech Therapy	☐	☐	Vision Therapy	☐	☐
Riding Therapy	☐	☐	Feeding Therapy	☐	☐

Equipment:

Does your child have any specialized equipment? ☐ No

☐ Tumble form	☐ Corner Seat	☐ Dolphin Bath Chair	☐ Blue Wave Toilet Seat
☐ High Chair	☐ Leckey Activity Chair	☐ Starfish Bath Chair	☐ Commode Chair
☐ Special Tomato	☐ Leckey Advance Bath Chair	☐ Flamingo Bath Chair	☐ Drop-Arm Commode
☐ Rifton Chair	☐ Otter Bath Chair	☐ Blue Wave Bath Chair	☐ Flamingo Toilet Seat

Does your child have any braces or orthotics? ☐ No

☐ SPIO Vest	☐ Benik Vest	☐ Thumb-Spica Orthotic	☐ Benik Hand Orthotic
☐ SPIO Pants	☐ Resting Hand Orthotic	☐ Wrist Cock-up Orthotic	☐ Shaping Helmet
☐ SPIO Shirt	☐ Antispasticity Orthotic	☐ Ulnar Gutter Orthotic	☐ Joe-Cool
☐ Theratogs	☐ Saddle Orthotic	☐ Elbow Extension Orthotic	☐ Bamboo Brace
☐ Under Armor	Other:_____		

Prior Level of Functioning:

Bathing:	☐ Independent	☐ Age Appropriate	☐ Needs Assistance	☐ Dependent
Dressing:	☐ Independent	☐ Age Appropriate	☐ Needs Assistance	☐ Dependent
Grooming:	☐ Independent	☐ Age Appropriate	☐ Needs Assistance	☐ Dependent
Feeding:	☐ Independent	☐ Age Appropriate	☐ Needs Assistance	☐ Dependent
Toileting:	☐ Diapers	☐ Toilet Trained	☐ Independent	☐ Needs Assistance ☐ Dependent
Crawling:	☐ Independent	☐ Age Appropriate	☐ Needs Assistance	☐ Dependent
Walking:	☐ Independent	☐ Age Appropriate	☐ Needs Assistance	☐ Dependent

Learning: (Please check any areas that your child is experiencing problems in):

Attention Span: ☐ Short ☐ Average ☐ Long

Behavior: ☐ Difficult to comfort ☐ Cooperative ☐ Transitions poorly ☐ Difficulty interacting with peers ☐ Frequent verbal outbursts ☐ Frequent behavior/temper outbursts

Education Difficulties: ☐ Basic Concepts ☐ Reading ☐ Reading comprehension ☐ Spelling ☐ Handwriting

Interaction Skills: ☐ Plays well with others ☐ Prefers to play alone ☐ Dislikes people in personal space ☐ Plays near others without interacting

Please answer the following statements.	Yes	No
Expresses distress during hair cutting.	☐	☐
Has difficulty standing in line or close to people.	☐	☐
Eats a limited variety of food.	☐	☐
Becomes anxious or distressed when feet leave the ground.	☐	☐
Seeks all kinds of movement including running, jumping, spinning.	☐	☐
Jumps from one activity to another.	☐	☐
Is distracted and has trouble focusing.	☐	☐
Seems to have weak muscles.	☐	☐
Holds hands over ears to protect ears from sounds.	☐	☐