TOTAL Pediatric THERAPY

Physical • Occupational • Speech

OCCUPATIONAL THERAPY PATIENT HISTORY

PATIENT HISTORY

Child's Full Name :

Child's Age :

Have you received physical therapy, occupational or speech/feeding treatments this year? ☐ Yes ☐ No

If yes, please explain:

Do you have concerns or input for the following areas? If so, please detail in the provided area.

Occupational Areas of Development	Examples	Strengths or Concerns
Fine Motor	• Grasp • Hand Use • Tool Use (Scissors, Pencils)	
Self Help Skills	• Utensil Use • Dressing • Managing Fasteners (Buttons, Zippers)	
Sensory	Response To: • Sound • Touch • Textures • Movements	
Play Skills	• Interactions with Peers or Toys • Favorite Play Activity or Toy	

GOALS

What do you hope to get out of occupational therapy treatments? What goals do you have?

Patient or Legal Guardian Signature **Date:**