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# Background Information: Preschool

## I. General Information

Date___________________________

| All Parent/Guardian Names: | | |
|---|---|---|
| Street Address: | City/State/Zip: | |
| Phone: Home | Work: | Cell |
| Email Address: | | |
| Parent/Guardian Birth Date: | Social Security #: | |
| Emergency Contact: Name: | Relationship | Phone: |
| Child/Client Name: | | Gender: Male_____ Female_____ |
| Birth Date: | Age: | |
| Brothers/Sisters Names and Ages | | |
| Physician: | | |

## II. Medical Information:

Medical Diagnosis (If any:___________________________________________________________

**MEDICATIONS**:_____________________________________________________________________

| **Does your child have any of the following** | ___ Cerebral Palsy ____________________________________________ |
|---|---|
| ___ Attention Deficit (Hyperactivity) Disorder | ___ Prematurity ________________________________________________ |
| ___ Autism | ___ Food allergies/special diet______________________________________ |
| ___ Asperger's Syndrome | ___ Muscular weakness____________________________________________ |
| ___ Pervasive Developmental Disorder | ___ Seizures / Epilepsy___________________________________________ |
| ___ Tourette's Syndrome | ___ Vision problems______________________________________________ |
| ___ Learning Disabilities | ___ Hearing problems_____________________________________________ |
| ___ Bipolar Disorder | ___ History of ear infections or tubes in ears (please circle)____________________ |
| ___ Anxiety | ___ Asthma____________________________________________________ |
| ___ Depression | ___ Allergies (latex, medication)_____________________________________ |
| ___ Posttraumatic Stress Disorder | ___ Stomach or intestinal problem:___________________________________ |
| ___ Panic attacks | ___ Casts or braces_______________________________________________ |
| ___ Obsessive Compulsive Disorder | ___ Surgery____________________________________________________ |
| ___ Attachment Disorders | ___ Serious injury_______________________________________________ |
| ___ Other mental health disorder | ___Hospitalization_______________________________________________ |
| ___Speech / Language disorders | ___ Other_____________________________________________________ |

Has child had vision test? Yes/No Results? _________________ Has child had hearing test? Yes/No Results?________________

Has child been seen by occupational therapy in the past? If so, when, where and for what reason:____________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Please list and *include reports* from other evaluations or treatments your child has received (psychologist, PT, neurologist, OT, etc.)

Type Professional's Name Date

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

## III. Birth History

1. At birth, was there: induction ___Yes ___ No forceps/suction/vacuum used? ___Yes ___No

   C-section? ___Yes ___No Was the C-section planned? ___Yes ___No

2. Was the child full term or premature at birth (how many months old)?_______________________

3. At birth, were there any complications such as:

   Breech ___Yes ___No Difficulty breathing ___Yes ___No

   Fractures ___Yes ___No Jaundice ___Yes ___No

   Cord around neck ___Yes ___No Difficulty nursing ___Yes ___No

   Hospitalized or intensive care after birth ____Yes ___No if so, how long?_______________

   Other issues with pregnancy or birth or hospitalization:_______________________

   _______________________________________________________________________

4. Was your child adopted or in foster care? ___Yes ___No Child's age at adoption or when entered your care ____________

   If yes, adoption was: ____Domestic _____International: what country_______________________

   Please identify any important details of adoption or foster care, adjustment to new home, particular challenges, etc.

   _______________________________________________________________________

   _______________________________________________________________________

   _______________________________________________________________________

## IV. Childhood and Developmental History

1. Did child crawl? ___Yes ___No If yes, did child crawl with knees off the floor? ___Yes ___No

   If yes, was crawling phase brief? ___Yes ___No Did child drag a leg? ___Yes ___No

   Did child scoot instead of crawl? ___Yes ___No Did child slide? ___Yes ___No

2. Is child toilet trained in: bowel ___ Yes ___No bladder ___Yes ___No Is child fearful of sitting on toilet? __Yes ___No

   Are there accidents? ___Yes ___No How often________________________ Does child have constipation? ___Yes ___No

3. Please give approximate ages when milestones were met, or comment on anything unusual

   Roll over____________ Crawl________________ Chew solid food___________ Say words_______________

   Sit alone___________ Walk__________________ Drink from cup_____________ Say sentences_____________

4. Does the child have difficulty calming/soothing self? How does child calm/soothe self? ______________________

   _______________________________________________________________________

## V. School / Preschool /Daycare:

1. Where attending:____________________________________________________ Grade in school:______________

2. If in preschool, pre-kindergarten, developmental preschool, or daycare are there any difficulties learning colors, letters, numbers, sitting in circle time, peer relationships, and/or beginning reading work (as appropriate for age of child)? Please circle.

3. Are there any specific problems? ____________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

4. Does child receive special services, developmental preschool, Individual Education Plan (IEP), ISP, or 504 plan, developmental preschool? (please circle) ___Yes ___No Please describe:_____________________________________________________

____________________________________________________________________________________________

## VI: General:

What are your concerns with your child's function? ______________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

What are your goals and priorities for treatment? What are your child's goals / what does he/she want to be able to do?_________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

What are your child's gifts? What is he/she good at? What motivates your child?_____________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

## V. Sensory Processing Checklist:

Please check off the answer that most fits the child's responses and make comments if you would like. Some questions may not apply

| SENSORY SENSITIVITY: Does/Is child: | Often | Some-times | Rarely/ Never | Comments |
|---|---|---|---|---|
| **1.** dislike or feel bothered by: Baths/showers, hair brushing/combing, haircutting, shampooing, or drying hair, nail cutting, brushing or flossing teeth, washing face, using hand sanitizer, hands in messy things, bumps on bed sheets, band-aids **Please mark all that apply.** | | | | |
| 2. dislike or feel bothered by clothing: Wet clothes, clothing waistbands, tight clothing, loose clothing, clothing tags, clothing seam either straight or crooked, socks, certain clothing fabric, socks, shoes, sandals, jeans. **Please mark all that apply** | | | | |
| 3. dislike or feel bothered by touch to the body: having arms or back stroked, hugs, holding hands? **Please mark all that apply** | | | | |
| 4. dislike going barefoot on grass, sand, carpet, or dirty floor? | | | | |
| 5. prefer to touch rather than be touched? | | | | |
| 6. become angry/annoyed when bumped or pushed unexpectedly? | | | | |
| 7. tend to be more sensitive to pain than others? | | | | |
| 8. blink at bright lights or feel irritated by them? | | | | |
| 9. bothered or distracted by sounds: toilet flushing, public hand dryers, door slamming, baby crying, dog barking, telephone ringing, sirens/alarms, lawnmowers, nail filing, blender, vacuum, hair dryer, hair dryer, coffee grinder, fireworks **Please mark all that apply**. | | | | |
| 10. bothered or distracted by background sounds: whispering, chewing, radio/TV, refrigerator, fluorescent lights buzzing, talking, clock ticking, fans, water dripping, utensils against each other (spoon in bowl) **Please mark all that apply** | | | | |
| 11. bothered by sounds in certain places: crowds, concerts, movies, malls, restaurants, cafeterias, gymnasiums, parties, sporting events, parties **Please mark all that apply** | | | | |
| 12. bothered by smells in the environment. Please list:______________ ____________________________________________________ ____________________________________________________ | | | | |
| 13. seem overloaded by environmental stimulation? | | | | |
| 14. seem to be on sensory overload frequently? | | | | |
| **BODY AWARENESS: Does (or is) child:** | **Often** | **Some-times** | **Rarely/ Never** | **Comments** |
| 1. have difficulty finding objects in pockets/ backpack without looking? | | | | |
| 2. have difficulty noticing food on face or messy hands? | | | | |
| 3. have a high tolerance to pain / not to feel pain as much as others? | | | | |
| 4. bang head, bite or pinch self? **Please mark all that apply** | | | | |
| 5. engage in activities that would typically be painful to others. | | | | |
| 6. seem oblivious of bruises and heavy falls? | | | | |
| 7. chew or bite nails, or grind teeth? | | | | |
| 8. chew or lick on non-food items? | | | | |
| 9. bump into objects or people frequently? | | | | |
| 10. over or under-estimate the amount of force needed for a task? | | | | |

| BODY AWARENESS: Does (or is) child: continued | Often | Some-times | Rarely/ Never | Comments |
|---|---|---|---|---|
| 11. tend to spill or drop things? | | | | |
| 12. play or interact with others roughly (hug too hard, head butt, slam into others, rough "high five", etc.) | | | | |
| 13. seem clumsy or accident-prone? | | | | |
| 14. unaware how much force to use for an activity? | | | | |
| 15. seek excessive touch input (touching people or objects, rubbing surfaces or textures, etc.) | | | | |
| **BALANCE / MOVEMENT PROCESSING: Does (or is) child:** | **Often** | **Some-times** | **Rarely/ Never** | **Comments** |
| 1. get uncomfortable or vomit from movement activities (swings, car rides)? | | | | |
| 2. seem clumsy, bump into things or people? | | | | |
| 3. have poor balance or falls | | | | |
| 4. have difficulty with sudden starts or stops in the car or riding in car? | | | | |
| 5. have difficulty in the car on roundabouts (circular intersections?) | | | | |
| 6. seek head upside down? | | | | |
| 7. dislike swings? | | | | |
| 8. a "dare-devil" or unaware of safety concerns? | | | | |
| 9. seem to deliberately fall or tumble? | | | | |
| 10. like to spin self around? | | | | |
| 11. rock in seat or in bed? | | | | |
| 12. like strong movement such as spinning, jumping, stomping? | | | | |
| 13. fear heights or seem fearful if feet are off the floor (in chairs, playground equipment, etc.)? | | | | |
| 14. wrap legs around chair legs, place foot in chair, tip chair forward, etc.? **Please mark all that apply** | | | | |
| 15. seek excessive movement, in constant motion? | | | | |
| 16. walk on toes? | | | | |
| 17. shake head side to side or up and down **Please mark all that apply** | | | | |
| 18. upset /uncomfortable with head tilted back (hair shampooing, etc.)? | | | | |
| 19. become calmed by rocking? | | | | |
| 20. fearful when sitting in tall chair with feet off the floor? | | | | |
| 21. dislike going down slide? | | | | |
| **MOTOR SKILLS: Does (or is) child:** | **Often** | **Some-times** | **Rarely/ Never** | **Comments** |
| 1. seem reluctant to participate in physical games? | | | | |
| 2. have difficulty learning new motor activities? | | | | |
| 3. have difficulty following steps when putting something together? | | | | |
| 4. have difficulty learning to ride a tricycle? | | | | |
| 5. have difficulty catching balls? | | | | |
| 6. appear awkward climbing on playground equipment? | | | | |
| 7. approach new motor activities cautiously? | | | | |
| 8. imitate or follow simple motions to a song? | | | | |
| 9. hesitate or awkward going up and down stairs? | | | | |

| FINE MOTOR SKILLS: Does (or is) child: | Often | Some-times | Rarely/ Never | Comments |
| --- | --- | --- | --- | --- |
| 1. have poor or awkward crayon grasp? | | | | |
| 2. have difficulty with scribbling or pre-writing strokes if applicable (forming a line, circle, square, or cross, etc.)? | | | | |
| 3. if old enough, avoid or have difficulty using crayons for drawing? | | | | |
| 4. if old enough, avoid or have difficulty using scissors? | | | | |
| 5. have difficulty with buttons? | | | | |
| 6. have difficulty with zippers? | | | | |
| 7. have difficulty using spoon or fork? **Please mark all that apply** | | | | |
| 8. have difficulty performing fine motor tasks such as manipulating objects in the hand, opening containers, etc? | | | | |
| 9. isolate index finger to point or push a button? | | | | |
| 10. pick up object such as Cheerios between thumb and index finger? | | | | |
| 11. have difficulty manipulating toys (blocks, Legos, paintbrush)? | | | | |
| 12. turn pages of book? | | | | |
| **VISUAL PROCESSING: Does (or is) child:** | **Often** | **Some-times** | **Rarely/ Never** | **Comments** |
| 1. have difficulty learning colors, shapes, or sizes? **Please mark all that apply** | | | | |
| 2. have difficulty/slow to learn letters or numbers? **Please mark all that apply** | | | | |
| 3. have difficulty with eye contact? | | | | |
| **TASTE/EATING: Does (or is) child:** | **Often** | **Some-times** | **Rarely/ Never** | **Comments** |
| 1. have difficulty with foods having textures: slimy, smooth, soft, lump, or meats? **Please mark all that apply** | | | | |
| 2. have difficulty eating smooth foods with a few lumps (e.g., soup, mashed potatoes) or foods mixed together (soups, etc.)? | | | | |
| 4. have difficulty with chewy or crunchy foods? **Please mark all that apply** | | | | |
| 5. have difficulty eating new or unfamiliar foods? | | | | |
| 6. gag or choke with certain food? **Please mark all that apply** | | | | |
| 7. seem to be a “picky eater”? | | | | |
| **EMOTIONAL / SOCIAL: Does (or is) child:** | **Often** | **Some-times** | **Rarely / Never** | **Comments** |
| 1. seem overloaded by environmental stimulation? | | | | |
| 2. have strong outbursts of anger or emotions? When do they occur: unpredictable, in certain places, after preschool, with peers, other_______________________________________________ **Please mark all that apply**. | | | | |
| 3. have difficulty calming self when upset ? | | | | |
| 4. tend to startle easily? | | | | |
| 5. difficulty with changes in routines? | | | | |
| 6. difficulty with transitions? | | | | |
| 7. hit or bite others? | | | | |

| EMOTIONAL / SOCIAL: Does (or is) child: | Often | Some-times | Rarely / Never | Comments |
|---|---|---|---|---|
| 7. difficulty with transitions? | | | | |
| 7. hit or bite others? | | | | |
| 8. have difficulty engaging in group activities? | | | | |
| 9. have difficulty with social skills? | | | | |
| 10. have difficulty falling asleep, remaining asleep, frequent waking, nightmares: **Please mark all that apply** | | | | |

## VII. Primary Movement Patterns:

Please mark any items below that fit with your child.

**Hands Supporting**

_____ Frequent injuries with falls (doesn't put hand out to protect face)
_____ Lack of body and space awareness/boundaries
______ Poor social boundaries (aggressive, standoffish, isolated, easily becoming a victim, bully or being bullied)

**Babkin**

_____ Tongue out of mouth or mouth movements when using hands
______ Biting clothing, objects, or sucking thumb
______ Nail biting

**Babinski**

_____ Difficulties with fine motor coordination
_____ Difficulties with gross motor coordination
_____ Poor balance
_____ Poor running or skipping
_____ Trips easily, clumsiness
______ Walks on inside of feet
______ Walks on outside of feet
______ Walks on toes
______ Walks with toes inward
______ Walks with toes outward

**Foot Tendon Guard**

_____ Difficulty standing
_____ Improper crawling
_____ Poor coordination for climbing
_____ Poor coordination for jumping
______ Poor coordination for running
______ Poor grounding and stability
______ Poor walking pattern

**Leg Cross Flexion Extension**

_____ Difficulty balancing on each foot
_____ Difficulty coordinating legs to ride a bicycle
_____ Hesitant when going down or climbing stairs
______ Poor coordination across the middle of body
______ Postural problems

**Moro**

_____ Becomes overly excited after movement activities
_____ Breath holding with effort
_____ Fearful of feet leaving ground
_____ Hypersensitive to movement (i.e. does not like head tipped backwards)
______ Motion sickness
______ Poor balance, motion sickness
______ Shallow breath patterns
______ Seeks intense movement frequently

**Fear Paralysis**

_____ Difficulty completing tasks when sounds are nearby
_____ Excessive reaction to touch
_____ Hypervigilance
_____ Hears sounds others do not hear
______ Hypersensitivity to sounds
______ Hypersensitivity to touch
______ Hypersensitivity to visual information
______ Overly sensitive to loud noises
______ Visually distracted

**Symmetrical Tonic Neck Reflex**

_____ Bumps into objects/people frequently
_____ Can't move hands, arms, head separately
_____ Difficulty visually tracking objects
_____ Discomfort and fatigue sitting with arms/legs bent or standing with arms/legs straight
_____ Difficulty sitting in chair for period of time; sitting On feet, feet wrapped around chair legs, etc.
______ Keeps eyes too close to paper
______ Moves as one unit
______ Prefers sedentary play
______ Problems with athletics
______ Avoids new physical challenges
______ Puts head down when drawing, reading, writing

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**Spinal Galant**

_____ Discomfort with tight fitting clothing or clothing waistbands
_____ Bladder accidents
_____ Hyperactivity
______ Poor gross motor coordination
______ Tends to adjust body/fidget frequently when sitting in a chair
______ Falls off chair

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**Spinal Perez**

_____ Sound hypersensitivity
_____ Bed wetting
_____ Delayed crawling and walking, difficulty with walking pattern
_____ Difficulty with potty training/bed wetting
______ Has difficulty controlling movements (too fast/slow, too hard/soft)
______ Leans on people/objects for stability
______ Plays roughly with people/objects
______ Touch hypersensitivity

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**Asymmetrical Tonic Neck Reflex**

_____ Difficulty following verbal directions
_____ Difficulty sequencing events
_____ Difficulty with attention, focus, memory
_____ Does not consistently respond to his/her name
_____ Frequently asks for repetition of directions/verbal Information
______ Letter/number/word reversals
______ Lack of hand dominance
______ Says "what?" or asks for repetition
______ Difficulty turning, rotating or twisting the body
______ Difficulty with handwriting
______ Difficulty throwing and catching
______ Sound sensitivity

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