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Background Information: Teenagers and Adults

I. General Information

Date_____

Client Name:		Gender: Male_____ Female_____
Birth Date:	Age:	
Street Address:	City/State/Zip:	
Phone: Home	Cell:	Work:
Email Address:		Social Security #:
Emergency Contact: Name:	Relationship	Phone:
Physician:		
School (Including Grade in School) or Employment:		
Referred by:		
Parent/Guardian Names (if client a minor):		
Parent/Guardian Date of Birth:	Social Security Number:	
Phone: Home	Cell:	Work:

II. Medical Information:

Medical Diagnosis (If any):_____

MEDICATIONS TAKEN:_____

Does the client have any of the following	
___ Attention Deficit (Hyperactivity) Disorder	___Speech / Language disorders_____
___ 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_____
___ Anxiety	___ Tubes in ears_____
___ Depression	___ Allergies or asthma_____
___ Posttraumatic Stress Disorder	___ Allergies (latex, medication):_____
___ Panic attacks	___ Stomach or intestinal problems:_____
___ Obsessive Compulsive Disorder	___ Casts or braces:_____
___ Attachment Disorders	___ Surgery:_____
___ Other mental health disorder	___ Serious injury:_____
	___ Other:_____

Describe any hospitalizations:_____

Date and results of: Vision test _____ Hearing test_____

Has the patient 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 the client has received (psychologist, PT, neurologist, OT, etc.)

Type Professional's Name Date

_____

_____

_____

_____

_____

Are there any medical precautions the therapist should be aware of?_____

If there has been any emotional or physical trauma you may describe if you wish:_____

_____

How does the client calm/relax? _____

_____

III. Birth History

1. Did the client's mother have problems or complications during pregnancy, delivery, or after birth?: ___Yes ___ No

   Please describe: _____

   _____

2. How many weeks old was the client when born (was birth early or late?)_____

3. At birth, were forceps/suction/vacuum used? ___Yes ___No

4. Was there a C-section? ___Yes ___No If yes, was it planned? ___Yes ___No

5. At birth, were there complications such as:

   Breech (feet first) ___Yes ___No Difficulty breathing ___Yes ___No

   Fractures ___Yes ___No Jaundice ___Yes ___No

   Bruising ___Yes ___No Cord around neck ___Yes ___No

6. After birth was there hospitalization? ___Yes ___No If yes, for how long?_____

7. Was the client adopted? ___Yes ___No If yes, at what age was the client adopted_____

   If yes, adoption was: _____Domestic _____International: what country_____

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

   _____

   _____

   _____

   _____

   _____

IV. Childhood and Developmental History

1. Did client crawl? ___Yes ___No If yes, was crawling with knees off the floor? ___Yes ___No

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

   Did the client scoot instead of crawl? ___Yes ___No Did the client slide? ___Yes ___No

2. 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_____

V. School / Work / Driving

1. Are there any problems at school or work with any of the following?

____Reading	____Math	____Spelling	____Social skills	___Test taking
____Handwriting	____Organizing work	____Remembering information	____Restlessness	___ Anxiety
____Finishing tasks	____Attention	____ Following directions	____Peer relationships	___ Homework

2. Are there any specific problems at work or school?_____

_____

_____

_____

_____

3. Does the client drive? ___Yes ___No If so, are there any difficulties with driving? If so, please describe:_____

_____

_____

VI. Sensory Processing Checklist:

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

SENSORY SENSITIVITY: Does or is the client:	Often	Some-times	Rarely/ Never	Comments
1. dislike or feel bothered by grooming/hygiene activities: Crooked socks, showers, baths, hair brushing/combing, haircutting, shampooing, or drying hair, nail cutting, brushing or flossing teeth, washing face, using hand sanitizer, showers, etc. **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, etc. **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. avoid getting hands into messy things?				
5. notice irritating bumps on the bed sheets?				
6. dislike going barefoot on grass, sand, carpet, or dirty floor?				
7. prefer to touch rather than be touched?				
8. become angry/annoyed when bumped or pushed unexpectedly?				
9. tend to be more sensitive to pain than others?				
10. 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**				
11. bothered or distracted by background sounds: whispering, radio/TV, refrigerator, fluorescent lights buzzing, talking, clock ticking, fans, water dripping, utensils against each other (spoon in bowl) **Please mark all that apply** _____				
12. bothered by sounds in certain places: crowds, concerts, movies, malls, restaurants, cafeterias, gymnasiums, parties, sporting events, parties **Please mark all that apply** _____				

SENSORY SENSITIVITY (continued): Does or is the client:	Often	Some-times	Rarely/ Never	Comments
13. bothered by smells in the environment. Please list:_____ _____				
14. blink at bright lights or feel irritated by them?				
15. become easily distracted by visual stimulation?				
16. seem overloaded by environmental stimulation?				
17. seem to be on sensory overload frequently?				
BODY AWARENESS: Does or is the client:	**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?				
4. bang head, bite or pinch self? **Please mark all that apply**				
5. engage in activities that would typically be painful to others.				
6. tend not to feel pain as much as others?				
7. seem oblivious of bruises and heavy falls?				
8. chew or bite nails, or grind teeth?				
9. chew or lick on non-food items?				
10. bump into objects or people frequently?				
11. over or under-estimate the amount of force needed for a task?				
12. tend to spill or drop things?				
13. play or interact with others roughly (hug too hard, head butt, slam into others, rough “high five”, etc.)				
14. seem clumsy or accident-prone?				
15. seek excessive touch input (touching people or objects, rubbing surfaces or textures, etc.)				
BALANCE / MOVEMENT PROCESSING: Does (or is) the client:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. walk on toes?				
2. move in and out of the chair?				
3. wrap legs around chair legs, sit cross-legged in chair, place foot in chair, tip chair forward, etc.? (please circle)				
4. have difficulty on escalators or elevators?				
5. seem clumsy or accident-prone?				
6. have difficulty sitting still in a meeting or class?				
7. have difficulty riding in a car unless in front seat or if a passenger (vs. driver)?				
8. have difficulty with sudden starts or stops in the car?				
9. have difficulty riding in the car on roundabouts?				
10. have difficulty looking at moving objects?				
11. have difficulty with balance or feeling unstable?				

BALANCE / MOVEMENT PROCESSING: Does (or is) the client:	Often	Some-times	Rarely/ Never	Comments
12. have other experiences feeling unstable?_____ _____				
13. dislike going on swings?				
14. fear heights or seem fearful if feet are off the floor?				
15. fearful of riding a bicycle?				
16. seek excessive movement?				
17. in constant motion, running about, etc. **Please mark all that apply**				
18. jump a lot?				
19. seem to deliberately fall or tumble?				
20. like to spin self around?				
21. rock in seat or bed?				
22. seek activities where head is upside down				
23. a "daredevil" or unaware of safety concerns with movement?				
MOTOR SKILLS: Does or is the client:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. feel reluctant to participate in sports/games?				
2. have difficulty learning new motor activities (dance steps, sports)?				
3. have difficulty following the steps when putting something together?				
4. approach new motor activities cautiously?				
5. have difficulty performing tasks in sequence?				
6. have difficulty with motor tasks that have several steps?				
7. have difficulty swimming using the crawl or other strokes?				
8. have difficulty following two or three verbal directions given at once?				
9. misunderstand the meaning of “up”, “behind”, “on your back”, etc.?				
10. have trouble learning to ride a bicycle?				
11. have difficulty catching balls?				
12. have difficulty with handwriting?				
13. have difficulty performing fine motor tasks such as manipulating objects in the hand, opening bottles, etc?				
14. have difficulty handling eating utensils: knife, fork? **Please mark all that apply**				
15. have difficulty cutting or spreading with a knife? **Please mark all that apply**				
VISUAL PROCESSING: Does or is the client:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. draw some numbers and letters backwards?				
2. skip letter, words, or lines of text when reading?				
3. complain of headaches when reading?				
4. avoid or have difficulty with eye contact?				

VISUAL PROCESSING: Does or is the client:	Often	Some-times	Rarely/ Never	Comments
5. have trouble following objects with eyes?				
6. have difficulty following traffic signs while driving?				
7. see double?				
8. close one eye or tilt head when reading?				
9. have trouble finding an object in a busy background?				
10. become easily distracted by visual stimulation?				
TASTE AND EATING: Does or is the client:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. have difficulty with foods having textures: slimy, smooth, soft, lump, or meats? (please circle)				
2. have difficulty eating smooth foods with a few lumps (e.g., soup, mashed potatoes)?				
3. have difficulty with foods mixed together (casseroles, soups, etc.)?				
4. have difficulty eating new or unfamiliar foods?				
5. gag or choke with certain food (please circle)				
6. seem to be a “picky eater”?				
GENERAL / EMOTIONAL / SOCIAL: Does the client:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. have strong outbursts of anger or emotions or must use effort to control emotions?				
2. have difficulty calming self when upset?				
3. tend to startle easily?				
4. have difficulty engaging in group activities?				
5. have difficulty with social skills?				
6. have difficulties with changes in routines or transitions?				
7. have difficulty falling asleep, remaining asleep, frequent waking, nightmares: **Please mark all that apply**				

VII. Primary Motor Reflex Patterns:

Please mark any items below that fit with the client.

Babkin

_____ Tongue out of mouth or mouth movements when using hands
_____ Biting clothing or objects
_____ Nail biting

Babinski

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

Foot Tendon Guard

_____ Difficulty standing
_____ Poor coordination for climbing
_____ Poor coordination for running
_____ Poor walking pattern

Leg Cross Flexion Extension

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

Moro

_____ Fearful of feet leaving ground
_____ Breath holding with effort
_____ Hypersensitivity 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
_____ Has difficulty completing task with sounds nearby
_____ 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
_____ Moves as one unit
_____ Difficulty visually tracking objects
_____ Discomfort and fatigue sitting with arms/legs bent or standing with arms/legs straight
_____ Puts head down when drawing, reading, writing
_____ Keeps eyes too close to paper
_____ Difficulty sitting in chair for period of time; sitting on feet, feet wrapped around chair legs, etc.
_____ Problems with athletics
_____ Avoids new physical challenges

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

Spinal Perez

_____ Sound hypersensitivity
_____ Bladder accidents
_____ Delayed crawling and walking
_____ Touch hypersensitivity
_____ Has difficulty controlling movements (too fast/slow, too hard/soft)
_____ Leans on people/objects for stability
_____ Plays roughly with people/objects

Asymmetrical Tonic Neck Reflex

_____ Difficulty following verbal directions
_____ Difficulty sequencing events
_____ Difficulty with attention, focus, memory
_____ Often asks for repetition of verbal Information
_____ Letter/number/word reversals
_____ Sound sensitivity
_____ Difficulty with handwriting
_____ Difficulty turning, rotating, or twisting body
_____ Difficulty throwing and catching

VI: General: What are your concerns and goals for treatment?_____

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