LLA THERAPY CHILD HISTORY FORM FOR CAMPS

GENERAL INFORMATION

Child's Name:____Age:______________________________

Name by which your child is called: ______________________________________Date of Birth:______________________

Pediatrician: ______________________Diagnosis:________________________ Referred by:_________________________

Briefly describe your child's problems:____
____
____
____

Briefly describe your child's strengths:____
____
____
____

The child lives with:____

Names of siblings/ages:____

MEDICAL HISTORY

The child's current health is ☐Good ☐Fair ☐Poor

Please list all current medications being taken by your child:

Medication Dosage Reasons for medication

____
____
____
____

Please list any allergies (medicine, food, environmental):

____
____
____

SPEECH-LANGUAGE

Does your child:

Answer when you talk to him/her?	☐ Sometimes	☐ Yes	☐ No
Talk about what he/she is doing?	☐ Sometimes	☐ Yes	☐ No
Have trouble pronouncing words?	☐ Sometimes	☐ Yes	☐ No
Hesitate, repeat or stutter words?	☐ Sometimes	☐ Yes	☐ No
Can your family understand your child's speech?	☐ Sometimes	☐ Yes	☐ No
Can people outside your family understand your child?	☐ Sometimes	☐ Yes	☐ No

When you talk to your child, how much does he/she understand? Check all that apply.

☐ A few words ☐ Simple directions ☐ Questions

☐ Many words/phrases ☐ Complex directions ☐ Almost everything I say

How does your child usually let you know what he/she wants? Check all that apply.

☐ Points to objects ☐ Uses sign language ☐ Makes a few sounds ☐ Uses gestures

☐ Grunts ☐ Uses a few words ☐ Uses 2-3 word phrases ☐ Uses sentences

What does your child like to talk about?____

____

OCCUPATIONAL THERAPY SKILLS

Does your child have an established hand dominance? Yes: Left Right No
Does your child use writing tools successfully? Yes No
Does your child cut with scissors? Yes No
Is your child resistive to different textures like glue, paint, etc? Yes No
How much assistance is needed with grooming tasks? None Minimal Totally Dependent
How much assistance is needed with dressing tasks? None Minimal Totally Dependent

SOCIAL-EMOTIONAL:

How does your child get along with other children?____

Does your child prefer to play alone or with other children?____

Does your child seem overly sensitive to criticism? ☐Yes ☐No
Does your child seem overly anxious or fearful? ☐Yes ☐No
Does your child tend to be quiet or withdrawn? ☐Yes ☐No
Does your child tend to be easily frustrated? ☐Yes ☐No
Does your child tend to be unusually uncooperative or stubborn? ☐Yes ☐No
Does your child have temper tantrums or outburst of anger? ☐Yes ☐No

ORGANIZATION:

Does your child frequently lose things (i.e. homework, coat)? ☐Yes ☐No
Does your child have difficulty tolerating changes in plans? ☐Yes ☐No
Does your child need extra assistance to get started with a task? ☐Yes ☐No
Does your child become easily distracted while working/playing? ☐Yes ☐No
Does your child have a short attention span? ☐Yes ☐No

EDUCATIONAL HISTORY

Is your child enrolled in school or pre-school? ☐Yes ☐No *(if no, skip this section.)*
Name of school or pre-school:____
Grade:__________________
How does your child do in school?____
____
____

Does your child receive any special education services? ☐Yes ☐No

Special Education Services	**Frequency (times per week)**	**Duration (minutes)**
Speech-Language Therapy		
Occupational Therapy		
Physical Therapy		
Guidance Services		
LD Support Services		
DH Support Services		
Other:		

SOCIAL WORK INFORMATION

Are there any community agencies active with your child? ☐Yes ☐No
Agency name:____

THERAPY HISTORY

Has you child been previously tested for therapy services? ☐Yes ☐No
If yes, where and when?____.
Does your child currently receive therapy services elsewhere? ☐Yes ☐No
If yes, where and when?____ *If no, skip this section*

Therapy received:

☐Physical Therapy Frequency_______________
☐Occupational Therapy Frequency_______________
☐Speech Therapy Frequency_______________
☐Other Frequency_______________

ACTIVITY INFORMATION

Describe interests, play activities and toys that your child likes best:
____
____

SOCIAL GROUP QUESTIONS:

Childs likes and dislikes:____

Please answer yes or no to the following questions:

Able to greet and say goodbye appropriately	☐Yes	☐No
Makes eye contact	☐Yes	☐No
Keeps appropriate distance from people during conversation (not to far or to close)	☐Yes	☐No
Is polite (please, thank you etc)	☐Yes	☐No
Asks appropriate questions	☐Yes	☐No
Answers questions appropriately	☐Yes	☐No
Initiates conversation or a new topic	☐Yes	☐No
Stays on topic	☐Yes	☐No
Plays well with adults	☐Yes	☐No
Plays well with peers	☐Yes	☐No
Shy	☐Yes	☐No
Interrupts	☐Yes	☐No
Speaks to loud	☐Yes	☐No
Shares easily	☐yes	☐No
Impatient	☐Yes	☐No
Takes turns during conversation	☐yes	☐No
Takes turns during games/play	☐Yes	☐No
Follows the rules of games/play	☐Yes	☐No
Difficulty showing emotions or talking about them	☐Yes	☐No

Please remember to include any additional information (IEP, ETR, Progress Reports, etc.)

Name of the person completing this history and relationship to child: ____
Date:________________________________ ***Thank you for taking to time to complete this form.***