CARMEL
COUNSELING CENTER

OCCUPATIONAL THERAPY
CLIENT INFORMATION FORM

Child's Name: _________________________________ Date of Initial Session: ________________

What other services are you currently receiving/have you received in the past?
If yes, where and what services? Please include dates:
Physical Therapy: __________________________________ Speech Therapy: ____________________
Occupational Therapy: ____________________ Other Physician besides Primary Medical Physician:
____

MEDICAL/SOCIAL HISTORY

Were there any complications during pregnancy? Yes___ No___
Were there any complications during birth? Yes___ No___
If yes, please explain:____
Pregnancy was: _______ weeks Birth weight was: _______ pounds

Please list any illness, diagnoses, surgeries, and/or injuries?
____
____
____

Does your child have any allergies? Yes _____ No _____
If yes, please explain if they are managed, and any behavior/s exhibited as a result?
____
____
____

Does your child have a history of ear infections? Yes _____ No _____
If yes, please explain: ____

Has your child's vision been tested? Yes _____ No _____
Date Tested (if known): ____________________ By whom: _____________________________

Have there been any significant changes in your family recently (e.g., moving, deaths, divorce, or births)? ____

Did your children meet the typical developmental milestones? Yes _____ No _____
If no, please explain: ____

SCHOOL
Does your child attend school, homeschool, or daycare? Please specify: _______________________
Is your child receiving any support services at school? Yes _____ No _____
Please specify: ____
Does your child have any other problems that may affect learning? __________________________
____

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What are your child's strengths?

____
____
____

What are your child's interests?

____
____
____

Does your child have particular dislikes or fears?

____
____
____

What are your concerns about your child?

____
____
____

What have you been told by doctors, teachers, and/or others about your child's abilities and needs?____

____
____
____

What do you hope will be gained by having your child seen for occupational therapy?

____
____
____

Parent Signature:__________________________________**Date:**________________________