BOLD Pediatric Therapy Center
1815 NW 169th Place, Suite 3070
Beaverton Oregon, 97006
Phone: 971-249-2653
Fax: 503-747-4373

Child History Form – Physical Therapy and Occupational Therapy

At what age did your child do the following:

Hold head steady? _____

Roll over? _____

Sit alone? _____

Crawl? _____

Stand? _____

Walk alone? _____

Use stairs? _____

Jump with two feet? _____

Pedal a trike? _____

Reach and grasp an object? _____

Move objects between two hands? _____

Feed self with fingers? _____ with spoon? _____ with fork? _____

Drink from open cup? _____

Scribble? _____

Use scissors? _____

Does your child:

Want to be in control of all movements? ☐ yes ☐ no

Want to be in control of all touch/ tactile experiences? ☐ yes ☐ no

Seem uncoordinated or fall frequently? ☐ yes ☐ no

Seek an increased amount of: ☐ crashing ☐ spinning ☐ constant movement ☐ squishing/ hugs

Get tired easily or quickly? ☐ yes ☐ no Rock self frequently? ☐ yes ☐ no

Have difficulty learning new tasks? ☐ yes ☐ no

Get easily distracted? ☐ yes ☐ no Have decreased attention/ focus on tasks? ☐ yes ☐ no

Number of hours on screens per day: _____

Child's favorite play activities include: _____