



BOLD Pediatric Therapy Center  
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## Child History Form – Occupational Therapy

Do you have concerns about your child's skills in the following areas:

- Dressing  Toileting  Self-cares (ie brush teeth, nail care, hair care, etc)  Bathing
- Sleep  Handwriting  Fine motor manipulation  Eye-hand coordination
- Attention  Organization  Emotions/ moods  Social skills/ interacting
- Play  Direction following/sequencing  Learning new tasks
- Frustration tolerance  Transitioning skills  Endurance  Strength
- Visual focus/ attention to tasks  Tolerating changes in routines
- Finding objects in drawers

Write in O, U, S letters, if your child is overly sensitive ("O") to, OR under-responsive ("U") to, OR seeks ("S") the following:

- Unexpected sounds  Bright lights  Touch by others/ handling if an infant
- Climbing  Clothing or self-care activities (ie brush teeth)  Dark spaces
- Hear their name called  Changes in temperature
- Textures on lips or in mouth (ie food, mouthing toys)
- Rocking  Fast movement activities  Changes in temperature
- Busy environments (ie grocery store)  Changes of position
- Loud noises/voices  Messy play/ finger feeding