



FOCUS THERAPY SERVICES, INC.



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Occupational Therapy Case History Form

Patient Name: _____
Insurance Type: _____
Insurance Number: _____
Date of Birth: _____

General Information:

Why are you seeking therapy for your child: _____

Current problems (motor skills, feeding, hearing): _____

Current diagnosis if known: _____

Current medical history: _____

Surgeries and dates (tonsillectomy, tube placements, etc): _____

Major accidents or hospitalizations: _____

Allergies (if none, please write none): _____

Medical History:

Please provide the approximate ages at which your child suffered the following illnesses or conditions:

Allergies: _____ Asthma: _____ Chicken pox: _____
Colds: _____ Convulsions: _____ Croup: _____
Dizziness: _____ Draining ear: _____ Ear infection: _____
Encephalitis: _____ German measles: _____ Headaches: _____
High fever: _____ Influenza: _____ Mastoiditis: _____
Measles: _____ Meningitis: _____ Mumps: _____
Pneumonia: _____ Seizures: _____ Sinusitis: _____
Tinnitus: _____ Tonsillitis: _____

List any other illnesses not noted above: _____

Medications:

Medication Name:	Medical Use:	Frequency & Duration:

General Information:

School your child attends: _____

List the year/grade of your child: _____

Academic concerns: _____

Interaction with others (shy, aggressive, uncooperative, etc): _____

Does your child receive specialized services, or have an Individualized Education Plan (IEP): _____

Is your child currently seeing any other therapy specialists, and if so, who and when: _____

Mother's general health during pregnancy (illnesses, accidents, medications, etc): _____

List any unusual conditions that may have affected the pregnancy or birth: _____

Length of pregnancy: _____

Length of labor: _____

General condition after delivery: _____

Type of delivery: _____

Birth weight: _____

Developmental History:

Please provide the approximate age at which your child began to do the following activities:

Crawl: _____ Sit: _____ Feed self: _____

Walk: _____ Stand: _____ Dress self: _____

Use toilet: _____ Use single words ("mom", "dad", "no", "doggie"): _____

Please sign below:

(Patient or Patient's Guardian's Printed Name) (Date)

(Relationship to Child)

(Patient or Patient's Guardian's Signature) (Date)