Move. Learn. Play. Inc.
Occupational Therapy

Patient Medical History and Daily Living Skills

Child's Name:_____ DOB:_____

Was your child born full term: Yes No
Were there any complication at birth? Yes No
If yes, please explain:
_____
_____

Has your child had any major illnesses, injuries, surgeries, or hospitalizations? Yes No
If yes, please explain:
_____
_____

Does you child have any medical diagnosis by a physician? Yes No
If yes, please specify:
_____
_____

Does your child take any medications? Yes No
If yes, please specify:
_____
_____
_____
_____

Does your child have any known allergies? Yes No
If yes, please explain:
_____
_____

Does you child have an IEP or IFSP/Early Intervention services? Yes No
If yes, does your child receive occupational therapy at school? Yes No
Per insurance requirements, please provide a copy of your child's IEP (if applicable).

Does your child attend preschool? Yes No
If yes, where? _____
How frequently? _____

Phone: 910- 290- 2170 | Fax: 910-319-0567 | admin@movelearnplaync.com | www.movelearnplaync.com
1072 Hwy 210, Ste B Snead's Ferry, NC 28460

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Who does your child live with at home?

_____

_____

Does your child receive any other therapies? Yes No
If yes, please specify:

_____

_____

Are there any other medical
concerns?_____

_____

Did your child meet developmental milestones in the past? Yes No
Did your child crawl? Yes No Age:_____
Did your child walk? Yes No Age: _____
Please list any developmental delays:

_____

_____

Daily Living Skills

Eating/Feeding:
Is your child able to eat with utensils? Yes No
Is your child able to feed with fingers? Yes No
Can your child drink from an open cup? Yes No
Can your child drink from a straw? Yes No
Is your child a selective eater? Yes No
Do you frequent choking, gagging, pocketing food in cheeks? Yes No
Does your child take a nutritional supplement? Yes No

Please provider further information if needed:

_____

_____

_____

_____

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Dressing:
Does your child take off clothing? Yes No
Does your child put on clothing? Yes No
Does your child complete the following fasteners:
Zip jacket? Yes No
Buttons? Yes No
Does your child tie shoes? Yes No

Sensory Motor Skills

Does you child tolerate messy play on hands (eg. sand, slime, messy food, wet clothing)? Yes No
Does your child tolerate loud noises? Yes No
Does your child tolerate playground equipment? Yes No
Does your child tolerate bath time/shower? Yes No
Does your child present with negative behaviors/difficulty following directions? Yes No
Does your child sit a the table to complete tabletop tasks? Yes No
Please explain any answers provided:
_____
_____
_____
_____

We partner with **At Home Pediatric Therapy** for Speech Therapy Services. Would you be interested in a FREE Speech Therapy screening? Yes No

By circling yes to the above question, I authorize Move, Learn, Play to provide my information to At Home Pediatric Therapy for a speech screening.

I hereby consent that the information on this document is true and correct to the best of my knowledge.

_____ _____
Parent/Guardian Signature Date

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