Orbit & Oak Therapy at Galactic Sky Farm

Child's Information

Full Name: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Primary Language Spoken at Home: _____

Home Address: _____

Parent(s)/Guardian(s) Name(s): _____

Primary Contact Number: _____

Email Address: _____

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Text

Emergency Contact

Name: _____

Relationship to Child: _____

Phone Number: _____

Medical Information

Primary Care Physician (PCP): _____

PCP Phone Number: _____

Medical Diagnosis(es):

_____

_____

_____

_____

Are there any specialists your child is currently seeing? ☐ No ☐ Yes — If yes, please list below:

_____

_____

_____

_____

Allergies (food, medication, environmental): ☐ No ☐ Yes — If yes, please list:

_____

_____

_____

_____

Is your child currently taking any medications? ☐ No ☐ Yes — If yes, please list medication name and purpose:

_____

_____

_____

_____

Hearing & Vision

Has your child had a hearing screening or evaluation? ☐ Yes ☐ No

Date of last screening: _____

Results/Concerns: _____

Has your child had a vision screening or evaluation? ☐ Yes ☐ No

Date of last screening: _____

Results/Concerns: _____

Does your child wear: Glasses? ☐ Yes ☐ No

Hearing aids? ☐ Yes ☐ No

Developmental and Therapy History

Has your child previously received any of the following therapies?

☐ Occupational Therapy ☐ Behavioral Therapy (ABA)

☐ Physical Therapy ☐ Vision Therapy

☐ Speech and Language Therapy ☐ Feeding Therapy

☐ Other: _____

Is your child currently receiving any of the above therapies? ☐ No ☐ Yes — Please provide details:

_____

_____

_____

_____

How was your child meeting developmental milestones?

_____

_____

_____

_____

Areas of Concern

Please check all areas where you have concerns or would like support for your child.

Fine Motor Skills

☐ Difficulty using hands for small tasks (e.g., buttoning, zipping)

☐ Trouble holding and using utensils, crayons, or pencils

☐ Poor hand strength or endurance

☐ Difficulty cutting with scissors

☐ Poor handwriting or drawing skills

Gross Motor Skills

☐ Clumsy or uncoordinated movements

☐ Poor balance or frequent falls

☐ Difficulty with stairs, running, or jumping

☐ Weak core strength (slouches or tires easily)

☐ Trouble with ball skills (throwing, catching, kicking)

Sensory Processing

☐ Overreacts to sounds, textures, lights, or smells

☐ Seeks out movement or rough play constantly

☐ Avoids messy play (e.g., sand, finger paint)

☐ Difficulty staying seated or calm in busy environments

☐ Easily overwhelmed or upset by changes in routine

Self-Care Skills

☐ Difficulty dressing (e.g., fasteners, putting on shoes)

☐ Needs help with toileting beyond expected age

☐ Struggles with brushing teeth, hair, or bathing

☐ Trouble using eating utensils or drinking from a cup

☐ Avoids or struggles with independent feeding

Visual-Motor & Visual-Perceptual Skills

☐ Difficulty copying shapes, letters, or puzzles

☐ Poor eye-hand coordination

☐ Trouble tracking objects or reading across a page

☐ Gets frustrated with visual tasks like mazes or matching

Social & Play Skills

☐ Difficulty taking turns or playing cooperatively

☐ Trouble initiating or joining in play with peers

☐ Limited imagination or flexibility in play

☐ Prefers to play alone or only with adults

Emotional Regulation

☐ Has frequent meltdowns or tantrums

☐ Difficulty calming down after becoming upset

☐ Easily frustrated or discouraged

☐ Reacts strongly to minor changes or transitions

Executive Functioning

☐ Poor attention or easily distracted

☐ Trouble following multi-step directions

☐ Difficulty organizing tasks or materials

☐ Avoids or gives up on challenging activities

☐ Often loses things or forgets instructions

Feeding / Eating

☐ Picky eater with very limited food preferences

☐ Avoids certain textures, temperatures, or smells

☐ Gagging or choking during meals

☐ Difficulty chewing or swallowing

☐ Mealtime behaviors are highly stressful or disruptive

Other

☐ Sleep difficulties

☐ Delayed developmental milestones

☐ Difficulty with transitions or change in routine

☐ Other concerns (please describe): _____

Daily Routines

Sleep: Bedtime: _____ Wake time: _____

Does your child nap? ☐ Yes ☐ No

Sleep quality/issues: _____

Toileting: ☐ Fully Independent ☐ Needs Assistance ☐ Not Toilet Trained

Comments: _____

Education/Daycare Information

Name of School/Daycare: _____

Grade/Program: _____

Does your child have an IEP or 504 Plan? ☐ Yes ☐ No

If yes, please describe the goals/services:

_____

_____

_____

_____

Home Strategies

Have you tried any strategies or interventions at home to support your child's development?
☐ No ☐ Yes — Please describe:

_____

_____

_____

_____

What strategies, routines, or tools have been helpful for your child (e.g., visual schedules, sensory breaks, timers, reward systems)?

_____

_____

_____

_____

Are there any specific environments, activities, or interactions where your child tends to succeed or feel most comfortable?

_____

_____

_____

_____

Is there anything that consistently triggers difficulty or distress for your child?

_____

_____

_____

_____

Other Information

What are your goals for occupational therapy?

_____

_____

_____

_____

How does your child best learn or engage? (e.g., visual aids, repetition, movement)

_____

_____

_____

_____

Signature

I affirm that the information provided is accurate to the best of my knowledge.

Parent/Guardian Name (Printed): _____

Signature: _____

Date: ___ / ___ / _____