HAND IN HAND THERAPY

Guiding little hands. Growing big skills.

Person providing information
Name:_____ Relationship to client_____

Referral information:
Referring physician:_____ Phone:_____

Child's name: _____ DOB:_____

Medical History:
Does your child have any diagnoses? Yes / No _____
Allergies: Yes / No _____
Medications: _____
Dietary considerations:_____
Hospitalizations, surgeries, accidents, illnesses:_____
_____

Gestational History:
Born at _____ weeks
Please describe any gestational complications:_____
_____
Please describe any birth complications:_____
_____

Treatment History:
(Circle any that apply) OT PT ST ABA
Comments: _____
_____
_____
_____
At what age (approximately) did your child:
Sit_____ Crawl_____ Walk_____ Run_____ Speak_____
Put words together_____ Use sentences_____
What are your child's strengths / motivating activities and toys:_____
_____
_____

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Parent concerns:
Please briefly describe any concerns you have in the following areas
Behavioral / Social: _____
_____
_____
Sensory: _____
_____
_____
Fine motor: _____
_____
_____
Gross motor: _____
_____
_____
Self-care: _____
_____
_____
Speech: _____
_____
_____
Safety awareness:_____
_____
_____
Executive function:_____
_____
_____
Academics:_____
_____
_____
Other: _____
_____

Thank you so much for taking the time to complete this form thoroughly. Your insights help us better understand your child's unique strengths, challenges, and needs. We truly value your partnership and look forward to working together to support your child's growth and success!