Please fill out this form as completely as possible. This information is crucial for our evaluation process; your input gives us insight into your child’s everyday level of functioning. If you answer yes to any questions please try to give comments.

\*Please Note: After completion, please return this form, along with any other pertinent academic/ medical information (i.e. IEP, reports from other clinicians or therapists your child has seen) to our front desk team.

1. **PATIENT INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | **Date: \_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Gender:\_\_\_\_\_\_\_\_\_\_\_** | | **Level in School:\_\_\_\_\_\_\_\_\_\_\_** | |
| **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Mother’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Father’s Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Mother’s Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Contact Information:** | | | **Contact Information:** | | | |
| **House:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **House:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Work:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Work:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Mobile:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Mobile :** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Email:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Email:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Child’s Sibling(s) / Age(s) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **Parental Status: [ ] Separated [ ] Married [ ] Divorced [ ] Widowed** | | | | | | |
| **Child Lives with (check one): [ ] Birth Parents [ ] Adoptive Parents [ ] Foster Parents [ ] Parent and Step parent [ ] One parent [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Insurance:**   |  |  | | --- | --- | | **Primary Insurance** | | | Insurance Carrier: | Contract Number: | | Name on Card: | Group Number: |  |  |  | | --- | --- | | **Secondary Insurance** | | | Insurance Carrier: | Contract Number: | | Name on Card: | Group Number: |   **Please check the appropriate box below:** I, the undersigned, **☐certify** / **☐do NOT certify** that I (or my dependent) have insurance coverage with the entity(s) listed above and assign directly to Advanced Therapy Solutions, LLC all benefits from the above entity, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Advanced Therapy Solutions, LLC to release all information necessary to secure the payment of benefits. | | | | | | |
| Please describe why you are having your child seen for Occupational Therapy evaluation and your goals for your child:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |

1. **BIRTH HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Pregnancy** | | |  | **Health at Birth** | | |
| * Did the mother experience any abnormal bleeding, illnesses, injuries or any other medical complications during pregnancy? | Y | N |  | * Was your child pronounced healthy at birth? | Y | N |
| * Did the mother take any prescription medications, alcohol, cigarettes or drugs? | Y | N |  | * Did the baby experience difficulty breathing at birth? If yes, was oxygen needed? | Y | N |
| * Was your child adopted? If yes, provide the age he/she were adopted. | Y | N |  | * Were there any medical complications? | Y | N |
| * If your child was adopted, do they know? | Y | N |  | * Were there any congenital defects affecting the baby? | Y | N |
| **Delivery** |  |  |  | * Was the baby jaundice? | Y | N |
| * Was the delivery premature? If yes, how many weeks? | Y | N |  | * Did the baby spend any extra time at the hospital? | Y | N |
| * Was medication given to induce labor? If yes, what kind? | Y | N |  | * Was there a need for tube feeding or an IV? | Y | N |
| * During labor were any instruments used to assist with birth? | Y | N |  | * Was the baby bottled or breast-fed?   [ ] Bottled [ ] Breast-fed | Y | N |
| * What was the baby’s gestation age (week) and birth weight? | Age | Wgt |  | * Were there any complications with feeding? | Y | N |
| * Was the labor abnormal? (Prolonged, short) Please Specify. | Y | N |  | * Was the baby alert with normal muscle tone and color at birth? | Y | N |
| * Was it an unusual delivery? (i.e. breech, caesarean, forceps) Please specify. | Y | N |  | * Were there any congenital defects affecting the limbs, face, nerves, other body parts? Please explain. | Y | N |

1. **MEDICAL HISTORY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| * Does your child have any medical diagnosis (i.e. ADHD, Autism Spectrum Disorder, Hypotonia, Dysgraphia etc.)?   **Please Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Y | N |  | * Does your child have a history of ear infections? | Y | N |
| * Is your Child currently taking any medications?   **Please Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Y | N |  | * Has your child ever been hospitalized or had any type of surgery?   **Please Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Y | N |
| * Does your child have any allergies (food, medication or environmental)?   **Please Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Y | N |  | * Does your child have a history of stomach or GI problems?   **Please Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Y | N |
| * Are your child’s immunization record up to date? | Y | N |  | * Has your child ever had any type of physical injury (i.e. broken bone, muscle injury etc,) | Y | N |
| * Did any adverse reactions occur from the vaccines? | Y | N |  | * Has your child had a vision exam?   **Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Y | N |
| * Has your child ever experienced a seizure? If yes, please give dates, how often and the type. | Y | N |  | * Has your child had a hearing exam?   **Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Y | N |
| * Does your child have a history of respiratory or heart problems? | Y | N |  | * Has your child experienced any of the following (please circle): meningitis, high fever, chicken pox, pneumonia, tuberculosis |  |  |

1. **DEVELOPMENTAL HISTORY**

Please note what age your child achieved these milestones, please comment if any were skipped or not yet achieved. Some may not be applicable/ NA.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Age | | |  |  | Age | |
| * Roll over both directions |  | | | * Drink from an open cup |  | |
| * Sit independently |  | | | * Did your child start talking and then stop or lose words? |  | |
| * Crawl on hands and knees |  | | | * Demonstrate a hand preference, right or left? |  | |
| * Eat solid foods |  | | | * When did your child become toilet trained? |  | |
| * Cruise around furniture |  | | | * Dress himself/ herself independently |  | |
| * Walk independently |  | | | * Button and zip independently |  | |
| * Speak first word |  | | | * Ride a tricycle |  | |
| * Spoon feed himself/ herself independently |  | | | * Ride a bike without training wheels |  | |
| **Describe your child as an infant:** | | | | **Describe your child at present:** | | |
| * Good, non-demanding | | Y | N | * Mostly quiet | Y | N |
| * Cried a lot, fussy, imitable | | Y | N | * Talks constantly | Y | N |
| * Was alert | | Y | N | * Overly active | Y | N |
| * Was active | | Y | N | * Tires easily | Y | N |
| * Was passive | | Y | N | * Impulsive | Y | N |
| * Liked being held | | Y | N | * Restless | Y | N |
| * Liked being rocked | | Y | N | * Stubborn | Y | N |
| * Was tense when held | | Y | N | * Resistant to changes | Y | N |
| * Was floppy when held | | Y | N | * Over-reacts | Y | N |
| * Slept through the night easily | | Y | N | * Fights frequently | Y | N |
| * Had irregular sleep patterns | | Y | N | * Often happy | Y | N |
| **Describe your child at present:** | | | | * Frequent temper tantrums | Y | N |
| * Has difficulty separating from primary caregiver | | Y | N | * Falls often | Y | N |
| * Wanders off without caution | | Y | N | * Clumsy | Y | N |
| * Has nervous habits or tics (please specify) | | Y | N | * Has unusual fears (describe) | Y | N |
| * Wets bed | | Y | N | * Rocks self during activities (describe) | Y | N |
| * Poor attention span | | Y | N | * Bangs head on purpose | Y | N |
| * Easily gets frustrated | | Y | N | * Has difficulty learning new task (i.e. bike riding, drawing/ writing, throwing a ball, etc) | Y | N |

1. **SENSORY MOTOR HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Tactile (Touch) Sensory System**  Does your child..... | | | **COMMENTS** |
| * Mind being touched by others? | Y | N |  |
| * Startle to being touched unexpectedly (i.e. if someone accidentally brushes against them)? | Y | N |  |
| * Always have to have their hands clean? | Y | N |  |
| * Prefer to initiate cuddling or hugging? | Y | N |  |
| * Mind getting messy or dirty (i.e. playing in sand, finger painting, glue etc.) | Y | N |  |
| * Avoid playing with messy things such as finger paint, sand, glue, glitter or clay? | Y | N |  |
| * Dislike going barefoot? ( is it on certain surfaces such as sand or grass?) | Y | N |  |
| * Avoid certain textures of clothing ( i.e. jeans, sweaters, tighter materials etc.) | Y | N |  |
| * Prefer to wear long sleeves or pant legs regardless of weather? | Y | N |  |
| * Complain that bed sheets are too rough? | Y | N |  |
| * Prefer to touch rather than be touched? | Y | N |  |
| * Dislike grooming activities such as washing their face, brushing hair, hair cut or nail cut? | Y | N |  |
| * Seems to lack an awareness of touch? | Y | N |  |
| * Seems to have a need to touch everything and everyone around them? | Y | N |  |
| * Pull away from light touch? | Y | N |  |
| * Startle or over-react to being touched unexpectedly? | Y | N |  |
| * Only accepts touch from people he/she knows well? | Y | N |  |
| * Seems excessively ticklish? | Y | N |  |
| * Crave touch from others? | Y | N |  |
| * Appear to have an abnormally high or low pain tolerance? | Y | N |  |
| * Stands or sit away from a group when with other children? | Y | N |  |
| * Hurt others by pushing, bumping, pinching, and/or biting? | Y | N |  |
| * Isolate him/herself from other children? | Y | N |  |
| * Feel pain MORE or LESS than others? | Y | N |  |
| **Visual Sensory System**  Does your child.... | | | **COMMENTS** |
| * Maintain his/ her visual focus on a task or object less than is expected? | Y | N |  |
| * Have difficulty naming, discriminating, or matching colors, shapes or sizes? | Y | N |  |
| * Stare or look at an object longer than expected? | Y | N |  |
| * Seems sensitive to bright light? | Y | N |  |
| * Tilt their head to the side when looking at an object, reading or writing? | Y | N |  |
| * Rub or squint their eyes when looking at something? | Y | N |  |
| * Have difficulty identifying colors | Y | N |  |
| * Have difficulty discriminating between the size and shape of an object? | Y | N |  |
| * Dislike closing or covering their eyes? | Y | N |  |
| * Have difficulty with puzzles? | Y | N |  |
| * Skip lines when reading or writing? | Y | N |  |
| **Auditory Sensory System**  Does/ is your child... | | | **COMMENTS** |
| * Respond negatively to unexpected or loud noises (i.e. cover ears, run away, become upset, cry etc.) | Y | N |  |
| * Tend to notice sounds that others don’t notice? (i.e. clocks ticking, refrigerators) | Y | N |  |
| * Ask for the TV or radio to be lowered or turn off? | Y | N |  |
| * Become upset ( i.e. cover their ears, cry, ask to leave) in a noisy setting? | Y | N |  |
| * Distracted easily by background noises? (i.e. household sounds, vacuum cleaner, hair dryer, dishwasher) | Y | N |  |
| * Ask others not to talk, sing, or make noise? | Y | N |  |
| * Enjoys singing and dancing to music? | Y | N |  |
| * Seem confused about the direction from which sounds are coming? | Y | N |  |
| * Appear to make noises just to hear themselves? | Y | N |  |
| * Appear not to hear some sounds? Or appear hard of hearing? | Y | N |  |
| * Consistently respond to their name being called? | Y | N |  |
| * Appear not to hear what you say? | Y | N |  |
| **Language Skills**  Does/ is your child... | | | **COMMENTS** |
| * Have difficulty understanding phrases, directions, or stories other children her/his age can follow? | Y | N |  |
| * Start to talk and then stop or lose a number of words? | Y | N |  |
| * Does your child sometimes repeat phrases from books or videos rather than composing his/her own sentences to play or make requests? | Y | N |  |
| * Does your child often “echo” phrases back to you? | Y | N |  |
| **Proprioceptive System (Body Awareness)**  Does your child... | | | **COMMENTS** |
| * Grind her/his teeth? | Y | N |  |
| * Seem driven to push, pull, drag, lift, or drop heavy objects? | Y | N |  |
| * Have difficulty sitting erect, prefer to lie on the floor than sit for extended periods, tire easily in one body position? | Y | N |  |
| * Seem unsure how far to raise or lower body during movements such as sitting down or stepping over an object? | Y | N |  |
| * Chew on non-food or object? | Y | N |  |
| * Tend to break toys more than other children? | Y | N |  |
| * Crave jumping or falling into objects or people? | Y | N |  |
| * Seem to do things either too hard or too light (using either too much or too little muscle force)? | Y | N |  |
| * Appear to grasp objects either too hard or too light? | Y | N |  |
| * Have poor motor coordination with small objects (i.e. pencil, buttons)? | Y | N |  |
| * Play overly rough with others? | Y | N |  |
| * Seem unaware of how to move their body to do a motor task? | Y | N |  |
| * Crave hugging and/ or cuddling? | Y | N |  |
| * Crave rough play? | Y | N |  |
| * Walk into other people, walls or objects? | Y | N |  |
| **Vestibular System (Moving body in space)**  Does/ is your child... | | | **COMMENTS** |
| * Fall frequently or lose their balance easily? | Y | N |  |
| * Overly cautious on playground equipment or with motor activities? | Y | N |  |
| * Seem uncomfortable moving in space (i.e. lifting feet off of ground, stairs, heights)? | Y | N |  |
| * Frequently like to be inverted, tipped upside down, hang upside down, or enjoy doing lots of somersaults? | Y | N |  |
| * Get carsick easily? | Y | N |  |
| * Get nauseous and/ or vomit from movement (i.e. carnival rides, swinging)? | Y | N |  |
| * Dislike swinging or carnival rides? | Y | N |  |
| * Dislike being tossed in the air? | Y | N |  |
| * Dislike spinning, bouncing and twirling? | Y | N |  |
| * Dislike tipping head backwards? | Y | N |  |
| * Have trouble catching self when falling? | Y | N |  |
| * Like to climb high and lack safety awareness? | Y | N |  |
| * Seems to spin and move around more than others? | Y | N |  |
| * Seems fearful of heights? | Y | N |  |
| * Seems not to get dizzy as much as peers? | Y | N |  |
| * Resist balance activities? | Y | N |  |
| * In constant motion, difficulty sitting still? | Y | N |  |
| **Postural Control**  Does/ is your child... | | | **COMMENTS** |
| * Have difficulty sitting upright on the floor? | Y | N |  |
| * Lean on objects or people when standing up? | Y | N |  |
| * Slump or hold their head in their hand when sitting at a desk/ table? | Y | N |  |
| * Seem weaker than peers? | Y | N |  |
| * Tire easily with motor task/ poor endurance? | Y | N |  |
| * Prefer more sedentary activities rather than playing outside? | Y | N |  |
| **Oral Motor**  Does/ is your child... | | | **COMMENTS** |
| * Crave certain texture of food (i.e. crunchy, soft, chewy etc)? Please specify | Y | N |  |
| * Crave certain flavours of foods (i.e. sweet, salty, sour etc.) Please specify | Y | N |  |
| * Have a history of reflux? | Y | N |  |
| * Gag when eating certain foods or food textures? | Y | N |  |
| * Chew on non food objects? | Y | N |  |
| * Use a pacifier or suck their thumb? | Y | N |  |
| * Become upset or sensitive to teeth brushed? | Y | N |  |
| * Require a special diet? | Y | N |  |
| * Have any feeding problems? | Y | N |  |
| **Gross Motor Skills/Motor Planning**  Does/is your child... | | | **COMMENTS** |
| * Have slow and deliberate movements with motor activities? | Y | N |  |
| * Move too fast and lose control? | Y | N |  |
| * Appear clumsy or awkward | Y | N |  |
| * Trouble getting themselves dressed? | Y | N |  |
| * Enjoys Phys. Ed. and Sports? | Y | N |  |
| * Have difficulty jumping or running? | Y | N |  |
| * Have difficulty learning new motor skills? | Y | N |  |
| * Able to jump on one foot? | Y | N |  |
| * Have difficulty kicking a ball? | Y | N |  |
| * Have difficulty catching and throwing a ball? | Y | N |  |
| **Fine Motor Skills**  Does/is your child... | | | **COMMENTS** |
| * Have difficulty with buttons, zippers and snaps? | Y | N |  |
| * Have difficulty manipulating small toys? | Y | N |  |
| * Have difficulty holding pencil? | Y | N |  |
| * Able to identify left and right hands? | Y | N |  |
| * Have difficulty copying shapes or drawing? | Y | N |  |
| * Have difficulty coloring within lines | Y | N |  |
| * Able to write along a line? | Y | N |  |
| * Reverse letters when writing? | Y | N |  |
| * Skip lines when copying a writing sample? | Y | N |  |
| * Have difficulty with spacing and sizing letters? | Y | N |  |
| * Complain of being tired when writing? | Y | N |  |
| * Frustrate easily when writing? | Y | N |  |
| **Gustatory/ Olfactory System (taste and smell)**  Does/is your child... | | | **COMMENTS** |
| * Respond to odors that others don’t notice? | Y | N |  |
| * Have a history of resisting new flavours or textures? | Y | N |  |
| * Like to taste non-food items such as glue or play dough? | Y | N |  |
| * Explores objects by smell? | Y | N |  |
| * Seem unaware of typical odors and scents? | Y | N |  |
| * React negatively to smell? | Y | N |  |
| * Gag or complain of nausea when smelling odors that don’t bother others? | Y | N |  |
| * Have unusual cravings for: salt, sour, bitter, sweet ? circle all that apply. | Y | N |  |
| * Acts as though all food tastes the same? | Y | N |  |
| * Have trouble with constipation? | Y | N |  |
| * Have trouble learning urinary control? | Y | N |  |
| * Have trouble learning bowel control? | Y | N |  |
| * Is your child toilet trained? | Y | N |  |
| * Have history of reflux? Is medication needed? | Y | N |  |
| **Social Adjustment**  Does/is your child... | | | **COMMENTS** |
| * Find it hard to make friends among his/her peers? | Y | N |  |
| * Prefer the company of adults or older children? | Y | N |  |
| * Prefer playing with younger children? | Y | N |  |
| * Play with age-appropriate toys? | Y | N |  |

1. **BEHAVIORAL HISTORY**

|  |  |  |
| --- | --- | --- |
| [ ] Friendly | [ ] Easy Going | [ ] Cooperative |
| [ ] Attentive | [ ] Good eye contact | [ ] Social |
| [ ] Flexible | [ ] Sleeps Well | [ ] Makes friends easily |
| [ ] Happy | [ ] Affectionate | [ ] Inattentive |
| [ ] Distracted Easily | [ ] Impulsive | [ ] Resists Change |
| [ ] High Activity Level | [ ] Aggressive | [ ] Stubborn |
| [ ] Cries Easily | [ ] Poor Sleeper | [ ] Acts out |
| [ ] Frustrates easily | [ ] Shy | [ ] Prefers socializing with adults |
| [ ] Passive | [ ] Poor eye contact | [ ] Socially awkward |
| [ ] Low self esteem | [ ] Separation Difficulties from parent | [ ] Prefers to play alone |
| [ ] Echo words spoken to them |  |  |

1. **EDUCATIONAL HISTORY:**

School/Daycare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child receive Special Education Service? If yes, what services?

Please describe your child’s school behavior (if applicable)

1. **SERVICES:**

Please list any recent psychological, educational, occupational therapy or speech and language evaluations your child has received. (If you wish to share any of the reports please provide them)

Has your child ever received occupational therapy services in the past? If yes, when and where?

1. **ADDITIONAL QUESTIONS**

What are your goals for your child to be addressed through occupational therapy services?

What are your child’s hobbies and favorite interests?

**\*If there are handwriting concerns, please bring work samples including composition, a math sample, and short answer/worksheet.**

**Appointment Reminders**

Would you like to receive a courtesy reminder for every scheduled appointment? (circle)

***Yes*** *or* ***No***

*-If yes, what type of reminder do you prefer?* ***E-mail Text Call***

***Please provide the phone number or e-mail address where you would like to receive reminders: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian Date

Thank you for taking the time to fill out this form, we look forward to meeting you and your child!