HOMEGROWN THERAPY SWFL

CHILD INFO

Name	DOB:	Caregiver's Name:	
Address:			
Parent's email address:			
Phone number:		Referral date:	
Child lives with:		Siblings in the house: if so please indicate ages	
Name:		Name:	Age:
Name:		Name:	Age:
		Name:	Age:
		Name:	Age:
Child's daytime routine: please circle one		Home with family	Homeschooled
School: If so please specify		Daycare: if so please specify	Other:
Primary language spoken in home:		Other languages if applicable:	Child's preferred language:

Janiellecraig@homegrowntherapyswfl.com 239-478-7059

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INSURANCE

Insurance:	Member ID:	Policy Holder name and DOB:

Secondary insurance:	Member ID and group ID	Policy holder name and DOB

MEDICAL INFORMATION

Pediatrician:	Pediatrician phone:	Last well check:
Pediatrician fax number:	Diagnosis:	

Gestation:	Delivery:	Birth weight:
Hospitalizations:	Is so date:	Surgeries:
Additional therapies:	Location of Therapy:	Day and time of therapy:

Allergies:	Does your child have any of the following
Medications:	Glasses _____ Hearing aids_____ Wheelchair_____ G-tube_____ Visual Impairments_____ Emotional/behavioral_____

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Other Specialists:	
Name:_____	Phone Number:_____
Name:_____	Phone Number:_____
Name:_____	Phone Number:_____
Name:_____	Phone Number:_____
Name:_____	Phone Number:_____
Name:_____	Phone Number:_____

DEVELOPMENTAL MILESTONES

Milestone	Age achieved:	Any complications:
Rolled over		
Sat unsupported		
Crawled on hands and knees		
Walked unsupported		
Held bottle		
Ate purees		
Finger fed small solids		
Drank from an open cup		
Toilet trained		

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Primary Concerns:		
How many hours of screen time per day does your child engage in?	Is your child okay if the screen is taken away/ battery dies?	Tablet/phone/ or television as main form of screen?
Please circle below what routines your child is independent in:		
Dressing: Socks Pants/shorts Shirts Zippers Buttons Snaps Shoes Tying Shoes	Feeding: Drinking from open cup Straw Fork Spoon Knife Preparing simple meals Opening snack packages	Hygiene: Brushing teeth Toileting Managing clothes for toileting Brushing hair Bathing in shower (body and shampoo) Washing hands

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FEEDING

Any feeding concerns? If your child has significant feeding concerns please complete the feeding evaluation.		
Would you classify your child as a picky eater?	Does your child tolerate playing with a variety of textures?	Does your child require assistance with feeding? If so how?
Does your child suck thumb/fingers?	Mouth objects?	Does your child use a pacifier?

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SENSORY

Any concerns for how your child manages activities out in the community?		
Does you child have a difficult time tolerating clothing? If so how?	Time your child goes to sleep and wakes up in the morning?	Any sleeping problems?
Can you child put themselves to sleep without outside sources (ex. Rocking, music, weighted blanket, bottle, Etc)	How long can your child sit to attend to an activity?	Would you classify your child as more active than other children? If yes does it interfere with school or home life?
Please circle below if you have observed your child doing any of the items below FREQUENTLY		
Covering ears from certain noises Repeating sounds from toys in close succession Gets distracted/overwhelmed in busy environments Runs into objects Runs and crashes into furniture Avoiding touching different textures	Spins body in circles Rocks body back and forth Watches tv upside down on the couch Difficulty sitting for activities Grinds teeth Difficulty sleeping	Walks on tip toes Watches objects spin/ makes wheels spin Fearful of swings/slides Chews on toys/clothes Falls frequently Flaps hands Prefers to lay down to play

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