

CHILD INFO

Name	DOB:	Caregiver's Name:		
Address:		Ι		
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 i	n home:	Other languages if applicable:	Child's preferred language:	





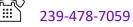
INSURANCE

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:		Surgerie	s:	
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		





Other Specialists:	
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		





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:	Feeding:	Hygiene:		
Socks	Drinking from open cup	Brushing teeth		
Pants/shorts	Straw	Toileting		
Shirts	Fork	Managing clothes for toileting		
Zippers	Spoon	Brushing hair		
Buttons	Knife	Bathing in shower (body and		
Snaps	Preparing simple meals	shampoo)		
Shoes	Opening snack packages	Washing hands		
Tying Shoes				





FEEDING

Any feeding concerns? If your child ha	s significant feeding concerns please cor	nplete 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?





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 observe	d your child doing any of the items below	FREQUENTLY
Covering ears from certain noises	Spins body in circles	Walks on tip toes
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	Rocks body back and forth Watches tv upside down on the couch Difficulty sitting for activities Grinds teeth Difficulty sleeping	Watches objects spin/ makes wheels spin Fearful of swings/slides Chews on toys/clothes Falls frequently Flaps hands
		Prefers to lay down to play

