Date: _____ **Name:** _____ **Date of birth:** _____
Parent Name: _____ **Referred by:** _____

Reason for seeking therapy (include for OT, PT & Speech):

_____

_____

What are your family's goals for therapy? _____

_____

Prenatal/Early Development:

Difficulties during pregnancy/labor/delivery? ___ Born Premature? ____ Birth Weight: _____
If yes to above please explain: _____

Age at which the following developmental milestones were achieved:

Rolling: ____ Sitting: _____ Crawling: ____ Walking: _____ Babbling: ___ First Word: _____

Does your child have a history of:

Allergies (seasonal, medications, food, etc): __ Frequent ear infections or ear tubes: ___
Seizures: ___ Surgeries or medical procedures: ___ Hospitalizations: ____
Broken bones or dislocations: ____ Visual problems or glasses: ____
Difficulties with hearing: ___ Hearing tested? Yes __ No ___ Date (if yes): ____
Gastrointestinal problems: ___ Cardiac/Heart Problems: ___ Breathing/Lung Problems: ___
Other: _____
If answered yes to any of above please explain: _____
_____

_____

Additional information:

Does your child use any equipment (orthotics, braces, wheelchair, walker, communication device)? _____
Has your child seen a specialist or had medical/diagnostic testing (x-ray/scan, vision, GI, cardiac, pulmonary, etc)? _____ Is your child up to date with vaccines? yes ___ No(explain below) ___
If answered yes to any of above please explain: _____
_____

Is your child currently receiving or has received any of these services:

Birth to Three: ____ School Based Therapy: ____ Private/Outpatient Therapy: _____

If yes please explain: _____

Languages spoken at home: _____

People who live with your child: _____

Describe your child's daycare, educational, and/or play settings: _____

_____

What are your child's favorite toys or activities? _____

Date: _____ **Name:** _____ **Date of birth:** _____
Parent Name: _____ **Referred by:** _____

Does your child have any behavioral challenges? If yes, please explain/provide strategies you have found effective: _____

Medications: ___ see attached list ___ none

Emergency Contact Information (*other than person accompanying this child to therapy*):

Name: _____ Relationship: _____ Phone: _____

To be completed by clinician – do not write below this line.

_____

__ Medical Database reviewed with family.

__ Attendance Policy/cancellation charge reviewed with family.

__ Standing appointments reviewed with family. __ Standing appointments not applicable

_____ _____

Therapist's Signature *Date*

Appointment Reminders: Offered either by email or text, please choose one option below:

__ Email: _____
__ Text: phone number: _____ Carrier: _____
__ No appointment reminders