Name:________________________________ DOB:___________________________

Concerns:

1. What are your current concerns? ____
____
____
____
____

2. When did you first have concerns about your child? ________________________
____

3. What specific skills would you like your child to achieve in therapy? ______________
____
____
____
____

Pregnancy and Birth History:

If any significant birth history or trauma please describe._________________________
____
____

Feeding History:

1. Do you have concerns regarding your child's feeding habits? YES / NO please describe ____
____
____
____

Medical History:

If you answer "yes" to any question, please explain in the space provided below.

1. Please check any and all of the following that your child has experienced.

____ Chicken Pox ____ Cleft Lip/ Palate ____ Vision Problems
____ Seizures ____ Gastroesophageal Reflux ____ Feeding Tube
____ Ear Infections ____ Fluid in the Ears ____ PE Tubes
How many? ____ When? ____

2. Is your child currently taking any medications? YES / NO
If yes, please list:____
____

3. Does your child have any known food allergies? YES / NO
If yes, please list:____
____

4. Does your child have any known drug allergies? YES / NO

If yes, please list:____
____

5. Has your child's hearing been evaluated? YES / NO
When:____
By Whom:____
Results:____
____

6. Has your child received therapy in the past? YES / NO
Speech / Occupational / Physical / Other
Where:____
When:____

7. Are there any other precautions, not described above, of which we should be aware? Y / N
____
____
____
____

Education:

1. Does your child attend school or day care? YES / NO
2. If yes, where?_______________________________ How often?_________________
3. What grade is your child in at the present time? ______________________________
4. Please check any services your child currently receives at school.

_____ Speech Therapy _____ Tutoring _____Physical Therapy
_____ Occupational Therapy _____ Other ______________________________

5. May we communicate with the school therapists to collaborate services? YES / NO
6. If yes, please list their information on the "Consent for Release" form and provide a copy of your child's most current IEP.
7. Does your child experience any specific challenges in school? YES / NO

If yes, please explain. ____
____
____

SELF CARE

Please check the amount of assistance needed for your child to complete the following:

	Independent (no help)	I assist (less than 50%)	I assist (more than 50%)	Dependent (total help)
Takes off pants:				
Puts on pants:				
Takes off shirt:				
Puts on shirt:				
Buttons				
Zipper				
Snaps				
Takes off Socks				
Puts Socks on				
Takes off shoes				
Puts shoes on				
Ties shoes				
Toileting				
Clothing management (toileting)				
Hand washing				
Bathing routine				
Teeth brushing				
Scooping with a spoon				
Spears with a fork				
Drinks from an open cup				
Drinks from a straw				