Department of Occupational Therapy

New Patient Information Sheet

Today's Date:

Child's Full Name:	Date of Birth: Age:
Address:	Contact Phone Number:
Email Address:	Insurance Provider:
Mother's Name: Father's Name:	Guardian's Name and Relation: (If child is in the custody of someone other than biological parents)
Who referred you to this clinic?	Name of Doctor/Pediatrician:
School/Preschool child attends: Name of Teacher: Grade: Which days do they attend? Typical ☐ Special Ed ☐ Resource ☐ IEP☐	Other children in the family: Name -Age -Grade _____ _____ _____ _____ Please place check by family members who live at home with child, including parents.
Previous or Current Therapy(ies), if so when? Occupational _____ Physical_____ Speech_____ Through which facility?	Any Precautions? Such as Seizures, Special Diet, etc.? Do you allow your child to eat candy? Y/ N

Developmental History

Birth weight:	Premature? If yes, how many weeks.
Normal Delivery ☐ Caesarean☐ Forceps☐	Medicated ☐ Natural☐
Any Complications (Baby): Any Complications (Mother): Any Medication or Drugs/Alcohol taken during pregnancy?	Any important illnesses, surgeries? ☐ Tonsils/Adenoid☐ GERD ☐ Any Surgery ☐ Seizures ☐ RSV ☐ Meningitis ☐ Strep Throat ☐ High Fever ☐ Allergies ☐ Developmental Regression ☐ Measles/Chicken Pox/Mumps
Current Medical Diagnosis: ☐ No Diagnosis At what age did your child… (NA- if not achieved) Roll_____ Sit alone_____ creep/crawl_____ pull to stand_____ Walk alone_____ First	Current Medications: Is your child able to (yes/no) … Dress himself___ Feed himself___ Bathe himself___ Comb hair___ Wash his hands___ Brush his teeth___ Fasten

Words_____ Jump with both feet____ Kick a ball____ Catch/Throw a ball_____ Ride a tricycle____ Feed self with utensil__	buttons, zippers, snaps___ Toilet Self___
Were there any unusual observations during the development of these skills, such as dislike of being on their stomach, not crawling on hands and knees, scooting on bottom, etc?	Have you noticed any differences compared to other children? Does your child get along/play with other children?
Are there any family/living situations which you think might affect your child's development or therapy? Does your child have separation anxiety? _____	Are there any eating concerns (picky eater, avoidance of food textures or tastes)
Any (biological) family history of learning disabilities or pertinent medical diagnoses? (Circle) ADD/ADHD Neurological Disorder Genetic Disorder Physical Disability Developmental Delay Immune System Compromise Learning Disability Autism/ Spectrum Disorder Mental Health Issue OTHER_____	Hearing test ☐ Outcome:_____ Vision test ☐Outcome:_____
Your child's strengths: Your child's weaknesses:	Your child's favorite activities, characters, toys?

What is your child's favorite candy, food, snack_____ _____ _____(this will be used as a reinforcer for good behavior.)

Concerns (PLEASE DO NOT LEAVE BLANK, PLEASE BE SPECIFIC- Thank You)

What has led you to seek services for your child?

_____

_____

Please describe your concerns about your child, citing specific areas (motor weakness, behaviors, academic difficulty, frustrations, self-help skills, peer relations, eating, etc.)_____

_____

_____

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What would you like us to help you and your child with?

_____

_____

_____

What is your top priority or goal for your child, right now?

Please note that parents are to remain in the waiting room while child is in treatment. Please call prior, if you know you are running late to treatment, or will not make it. Your child's care is very important to us, we would appreciate if you comply with homework assignments, projects and follow through. SIGN Thank You, Therapy Staff