giant leaps
occupational therapy, pc

REGISTRATION INFORMATION

Child's Name: _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone #: _____

Parent/Caregiver 1: _____

Cell #: _____ Work #: _____

Email Address: _____

Parent/Caregiver 2: _____

Cell #: _____ Work #: _____

Email Address: _____

Medical Diagnoses (If any): _____

Allergies:

If your child has an allergy, we ask that you complete and additional form. Please request Health History for a Child with Allergies.

Physician: _____

Address: _____

Telephone #: _____

Developmental and Medical History

Has your child had seizures? Yes No Age: _____
Type: _____ Frequency: _____

Any present medication(s)?

_____

_____

_____

_____

Has your child had a history of ear infections?
If yes, frequency: _____
Are there any other medical precautions the therapist should know about when working with your child?

_____

_____

_____

Were there any pregnancy or birth complications? Prematurity?

_____

_____

Developmental Skills

Please circle **all of the items** your child can perform. Please note the following skills typically develop around the ages indicated; however, these ages are merely a guide and are not definitive.

(0 – 3 mo.)

1.	Bring hands to midline while on back?	Yes	No
2.	Turn head to both sides while on back?	Yes	No
3.	Roll from side to back?	Yes	No
4.	Coordinate sucking, swallowing, and breathing?	Yes	No
5.	Turn head toward sound?	Yes	No

(3 – 6 mo.)

6.	Follow a moving object with eyes while in supported sitting?	Yes	No
7.	Reach for and grasp objects?	Yes	No

8.	Roll from back to side?	Yes	No
9.	Use tongue to move food in mouth?	Yes	No
10.	Sleep at night (for 10-12 hours without awakening)?	Yes	No
11.	Munch solid foods?	Yes	No
12.	Bring both feet to mouth?	Yes	No
13.	Maintain balance while sitting?	Yes	No
14.	Begin to transfer items from hand to hand?	Yes	No
(6 – 9 mo.)			
15.	Release objects voluntarily?	Yes	No
16.	Crawl forward and backward?	Yes	No
17.	Get to sitting without assistance?	Yes	No
18.	Pull to standing at furniture?	Yes	No
19.	Feed self a cracker?	Yes	No
20.	Drink from cup held by caregiver?	Yes	No
21.	Independently bottle-feed without a mess?	Yes	No
22.	Drool less except when teething?	Yes	No
23.	Look for objects when they disappear from sight?	Yes	No
24.	Play peek-a-boo?	Yes	No
25.	Move eyes independent of head movements?	Yes	No
(9 – 12 mo.)			
26.	Poke with index finger?	Yes	No
27.	Stand momentarily?	Yes	No
28.	Finger feed self?	Yes	No
29.	Hold a spoon?	Yes	No
30.	Cooperate with dressing by extending arm or leg?	Yes	No
31.	Attend to a book or toy for about 2 minutes?	Yes	No
32.	"Cruise" furniture and walls?	Yes	No
33.	Imitate a scribble?	Yes	No
34.	Remove socks and untie shoes?	Yes	No
35.	Imitate an adult's use of tools, such as combing hair?	Yes	No

36.	Attempt spoon-feeding?	Yes	No
37.	Pick up small objects using thumb and finger grasp?	Yes	No
(12 – 15 mo.)			
38.	Mark paper with crayon?	Yes	No
39.	Put three or more objects into a container?	Yes	No
40.	Build tower using 2 cubes?	Yes	No
41.	Stand-alone well?	Yes	No
42.	Throw underhand in sitting?	Yes	No
43.	Walk without support?	Yes	No
44.	Bend over and look through legs?	Yes	No
45.	Bring spoon to mouth – turn spoon over?	Yes	No
46.	Hold a cup handle?	Yes	No
47.	Drink from a cup without help?	Yes	No
48.	Throw a small ball?	Yes	No
49.	Open a book and turn a few pages at a time?	Yes	No
50.	Stir a spoon in a cup?	Yes	No
(15 – 18 mo.)			
51.	Scribble spontaneously?	Yes	No
52.	Use both hands at midline – one holds, other manipulates?	Yes	No
53.	Stand on one foot with help?	Yes	No
54.	Walk upstairs with one hand held?	Yes	No
55.	Indicate discomfort over soiled pants by verbal or gesture?	Yes	No
56.	Nap for 1-3 hours in afternoon?	Yes	No
57.	Remove socks?	Yes	No
58.	Brush teeth with assistance?	Yes	No
59.	Walk with no support?	Yes	No
60.	Jump down from a step?	Yes	No
61.	Hold a crayon in fist with thumb up?	Yes	No
62.	Kick a ball forward with good balance?	Yes	No

63. Point to two of own body parts?	Yes	No
(18 – 24 mo.)		
64. Push a stroller or cart?	Yes	No
65. Run?	Yes	No
66. Walk up stairs one at a time, without alternating feet?	Yes	No
67. Jump off the floor with both feet?	Yes	No
68. Crawl backward down stairs?	Yes	No
69. Zip and unzip a large zipper?	Yes	No
70. Attempt to put on shoes?	Yes	No
71. Remove all clothes without help?	Yes	No
(24 - 30 mo.)		
72. Imitate vertical and/or horizontal stroke?	Yes	No
73. Build a tower using 6 cubes?	Yes	No
74. Help with simple household tasks?	Yes	No
75. Have definite food preferences?	Yes	No
76. Walk upstairs alone – both feet on same step?	Yes	No
77. Jump backwards?	Yes	No
78. Jump sideways?	Yes	No
79. Reject many foods?	Yes	No
80. Insist on doing things independently?	Yes	No
(30 – 36 mo.)		
81. Run with whole foot contact? Stopping and starting?	Yes	No
82. Jump over objects?	Yes	No
83. Pull pants off and on?	Yes	No
84. Throw a ball while standing (without falling)?	Yes	No
85. Walk up and down stairs with alternating feet?	Yes	No
86. Balance on one foot for 10 seconds?	Yes	No
87. Wipe hands and face?	Yes	No
88. Ask for help with personal needs?	Yes	No
89. Initiate own play activities/entertain self?	Yes	No

90.	Pour well from a half-full pitcher?	Yes	No
91.	Put shoes on without tying?	Yes	No
92.	Wash and dry hands independently?	Yes	No
93.	Copy a circle?	Yes	No
94.	Build a tower using 8-10 cubes?	Yes	No
95.	Climb a jungle gym and ladder?	Yes	No
96.	Catch soft objects with both hands?	Yes	No

Challenges at Home	**How concerned are you?** **Not at all**				**Very**
Regularity of sleep	1	2	3	4	5
Bathroom routines	1	2	3	4	5
Mealtime behavior	1	2	3	4	5
Adaptation to change in routine	1	2	3	4	5
Socialization with peers	1	2	3	4	5
Resistance to new people/situations	1	2	3	4	5
Frustration tolerance	1	2	3	4	5
Mood	1	2	3	4	5
Regulating activity level	1	2	3	4	5
Following directions	1	2	3	4	5
Sibling conflict	1	2	3	4	5
Flexibility	1	2	3	4	5
Transitions	1	2	3	4	5

Services Currently Receiving

Service(s)	**Provider**	**Telephone**
☐ Occupational Therapy		
☐ Physical Therapy		
☐ Speech and Language		
☐ Psychology		
☐ Psychiatry		
☐ School Aid		
☐ Other		

Other Information

1. What are your child's strengths?

2. What would you like your child to achieve through occupational therapy?

3. Is there anything else you would like us to know about your child?

Daily Schedule

1. Does your child participate in an infant/toddler program(s)
   (such as "Mommy and Me" or another early childhood program)? Yes No

   Name of program/s: _____

2. What day(s) of the week is your child in this program? _____

3. What time of day is your child in this program? _____ to _____

4. Please describe your child's morning routine. What factors most interfere with a smooth morning?

5. Does your child play appropriately with toys? Yes No If not, explain:

6. Please describe your child's bedtime routine. What tends to relax or over stimulate him/her in the evening? How long does it take your child, once put to bed, to fall asleep?

7. Who is primarily responsible for discipline and rule setting at home? What methods are most effective? How does your child respond to discipline?

8. Does your child tantrum? Yes No How often? _____
   Have you observed any head banging or self-destructive behavior? Yes No
   If yes, explain:

9. How does your child respond to structure? Please elaborate:

Social Skills

1. How does your child function at birthday parties, other group or crowded situations (e.g. guests at home, visiting friends or relatives, sporting events, synagogue/church, mall, movie theatre, etc.)?