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?

_____

_____

Does you child attend:

☐ Nursery School/Preschool: _____

☐ Early Intervention Program: _____

☐ Regular Education ☐ Special Education

Developmental Milestones

(Give approximate ages if remembered, or comment on anything unusual)

Roll over	_____	Walk	_____	Say words	_____
Sit alone	_____	Chew solid food	_____	Say sentences	_____
Crawl	_____	Drink from a cup	_____	Toilet trained	_____

Was crawling phase brief? ☐ Yes ☐ No Absent? ☐ Yes ☐ No

Developmental Skills		
Can your child:		
1. walk up an down stairs with alternating feet?	Yes	No
2. climb on playground equipment?	Yes	No
3. throw a ball?	Yes	No
4. catch a ball?	Yes	No
5. draw lines and circles?	Yes	No
6. undress self?	Yes	No
7. participate in dressing?	Yes	No
8. kick a ball?	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. How does your child feel about himself or herself?

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

Daily Schedule

1. My child is in school from _____ to _____ .

2. Please describe your child's morning routine (typical school day). What factors most interfere with a smooth morning?

3. Please describe your child's usual after-school routine (overview). What are the biggest deterrents to a smooth evening?

4. Other than preschool, what type of activities is your child involved in? Why? Are you happy with those choices?

5. How does your child choose to spend his/her time when given free play?

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

Daily Schedule, con't

7. 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?

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

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

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

Social Skills

1. Is your child attuned to social cues? Is s/he socially appropriate (at preschool, home, play date, party)?

2. How does your child function with play dates? Does s/he request them?

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

4. If your child has siblings, how does s/he relate and play with them?