1940 Bonita Dr. Suite B
Aptos, CA 95003
831.684.1804
Fax: 831.684.1826

We appreciate the opportunity to work with you and your child. Please read through and complete all paperwork before your arrival. Please email back to our office if possible so the evaluating therapist can review information. We ask that you please arrive 15 minutes prior the start of your appointment. Thank you for your confidence in Pediatric Therapy Center and we look forward to working with you and your family.

Client Information

Date_____

Client's Name:_____ Date of Birth: _____/____/_____

Address:_____
_____

Parent/Guardian Information

Parent Name/Guardian:_____ (relation) _____

Cell Phone :_____Home Phone: _____Work:_____

Employer:_____ DOB:_____

E-Mail Address:_____

Address (if different than client's) _____

Parent Name/Guardian:_____ (relation)_____

Cell Phone :_____Home Phone: _____Work:_____

Employer:_____ DOB:_____

E-Mail Address: _____

Address (if different than client's) _____

Emergency contact & Relationship: _____

INSURANCE: YES NO

Circle one: HMO PPO CCAH CASH OTHER
HMO _____

Name of Insurance: _____

Billing Address: _____

City_____State____Zip_____

ID#_____Group#_____Deduct:$_____copay$_____

Name of Insured:_____DOB_____Relationship to client_____

Primary Care Physician: _____ Phone: _____

DO YOU HAVE A SECONDARY INSURANCE: YES NO
** We do not bill secondary insurances.

DO YOU HAVE SARC? YES NO
Case Worker name and number: _____

School Information

Name of School: _____ Current Grade:_____

Teachers Name:_____

Academic Concerns:_____

Does your child currently receive school based services? YES NO
If so, please provide types of therapy and frequency:
_____

CLIENT HISTORY

BIRTH HISTORY

Prenatal History

Please describe the pregnancy:

_____

Weight:_____ Duration of Pregnancy_____Type of Delivery_____
Any Complications at Birth? _____
Treatment Received by Baby or Mother?_____

Who lives at home with your child? (give brief description of family dynamic)

_____

MEDICAL HISTORY

Most recent hearing test: Date:_____Results:_____
Most recent vision test: Date:_____Results:_____
Number of ear infections: ____ Describe Treatment: _____
Are immunizations up to date? _____
Any medical or school diagnosis? _____
Current Medications: _____
Any other pertinent medical history: (i.e. injuries, hospitalizations, surgeries?)

_____

Does your child use glasses, hearing aid, braces, wheelchair or any other special equipment?

_____

Does your child **have allergies**, seizures or any other medical problems we should know about?

_____

Any other therapy and/or special education programs that your child have had or is currently receiving? (including, Chiropractic, Acupuncture, Psychotherapy etc.)_____

_____

DEVELOPMENTAL MILESTONES

Please list **the age at which your child was able to accomplish** these listed below**:**

Turn head side to side: _____Sit alone:_____ Lift head while on tummy: _____
Crawl/Creep: _____Roll Over: _____Pull to stand: _____
Cruise, walk with support: _____ Walk alone_____ Climb stairs:_____
Walk down stairs:_____ Chew:_____ Drink from cup:_____
Feed self with spoon:_____ Babble: _____ Say words:_____
Speak in phrases:_____ Speak in sentences:_____
Play with children:_____

GENERAL QUESTIONS

Why are you seeking out an evaluation?

_____

_____

What does your child like? What do you enjoy doing with your child?

_____

_____

What are your child's strengths?

_____

_____

What is more challenging for your child?

_____

_____

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

_____

_____

Is there anything else you would like us to know at this time that you feel can help us provide better services for your child?

_____

OT QUESTIONAIRRE:

Please, indicate the areas of concern that you are seeking support.

Please mark if area of concern	Body, Movement, and Motor Planning:	Additional comments
☐	Balance (i.e. frequently falls or trips)	
☐	Motor coordination (i.e. difficulty with climbing, throwing/catching balls, jumping jacks)	
☐	Poor body awareness (i.e. difficulty maneuvering around furniture/people/objects without bumping into them, seems accident prone)	
☐	Poor postural/core strength	
☐	Poor body strength	
☐	Seems to exert too much pressure for the task (slamming doors, pressing to hard when using pencils or crayons)	
☐	Grasps objects (such as spoon or pencil) loosely	
☐	Difficulty with imitating body movements (songs with motion 'itsy-bitsy spider', Simon says)	
☐	Avoids movement activities or using playground equipment	
☐	Dislikes when head is tilted upside down	
☐	Poor endurance/tires easily (especially when standing or holding particular body position)	
☐	Gets hurt often during play / poor safety awareness	
☐	Seeks out movement that is unsafe and/or interferes with daily routine	
	Fine Motor/Visual Motor:	
☐	Still switches hands – no hand preference/dominance	
☐	Awkward/immature grasp on marker/pencil	

☐	Avoids drawing, art, or writing activities	
☐	Poor handwriting (i.e. legibility, letter formation)	
☐	Difficulty with spacing and staying on lines when writing	
☐	Tires easily with writing activities or requires increased time to complete writing tasks	
☐	Difficulty with cutting with scissors	
☐	Difficulty with manipulating small items (i.e. blocks, Legos, constructions projects)	
☐	Difficulty with opening containers (play dough, snacks in bags etc.)	
	Feeding/Eating:	
☐	Likes to chew on nonfood items (examples: toys, shirt)	
☐	Has difficulty manipulating food in mouth (examples: chewing, closing lips fully, excessive drooling, gagging, choking)	
☐	Avoids eating new foods	
☐	Needs foods cooked/prepared certain way, or only likes a particular brand	
☐	Has a limited diet	
☐	Bothered by certain smells	
	Personal/Social: Behavior and Emotions:	
☐	Sharing and cooperation with friends (i.e. difficulty taking turns)	
☐	Participating appropriately in outings (i.e. difficulty in going to grocery store, birthday parties, parks)	
☐	Difficulty following directions	
☐	Difficulty with transitions	
☐	Difficulty with handling unexpected changes or changes in routine	
☐	Limited variety of play interests and imagination	

	Limited attention when participating in a task	
	Engages in repetitive or self-injurious behaviors that impede on functional performance	
	Self Care:	
	Utensils use (i.e. forks, spoons, drinks from a cup, cuts with knife)	
	Removing clothing/shoes	
	Putting clothing/shoes on	
	Tying shoes	
	Managing zippers, buttons, fasteners	
	Brushing hair & teeth, washes face & body	
	Following a 3-4 step routine/task	
	Organizing his/her own things, cleaning up room	
	Difficulties with sleeping (i.e. falling asleep, staying asleep)	
	Visual Processing:	
	Easily distracted looking at things in the room when completing a task	
	Sensitive to light (prefers to be in the dark)	
	Difficulty finding things in a cluttered space	
	Tends to draw or write with reversals	
	Auditory processing	
	Has speech or articulation difficulties	
	Seems bothered by ordinary household sounds (toilet flushing, hair dryer, vacuum)	
	Shows significant distress with unexpected sounds or loud noises (runs away, cries)	
	Appears to not hear what you say or hear name being called	

☐	Enjoys making unnecessary sounds (causing certain sounds to happen over and over again: excessively banging toys, yelling etc.)	
☐	Has difficulty remembering directions	
☐	Has difficulty functioning/completing a task if there is a lot of noise in the room (people talking, TV or music on)	
	Touch processing	
☐	Excessively seeks touching people and objects	
☐	Has a high pain tolerance/decreased awareness of pain and temperature	
☐	Avoids messy textures when playing (paint, glue, sand, etc.)	
☐	Shows distress to being touched	
☐	Shows distress with certain fabrics, clothing, shoes, or bed sheets	
☐	Shows distress with brushing hair, brushing teeth, bathing, nail clipping, hair cuts	

Additional comments:

_____

_____

_____

_____

_____

_____

_____

_____

Allergies/Food Permission/Dietary Information

Please list any allergies your child may have, including food, non-food, and/or latex:
_____
_____

Please complete the following to allow your child to participate in snack activities.
_____ My child may participate in snacks and has no diet restrictions.
_____ My child may participate in snacks if diet restrictions are observed.

Diet Restrictions:
_____ My child may participate in snacks; however, I will provide his/her snack.
_____ My child should not participate in snack time.

Video and Picture Release

_____ I give permission for my child's picture/video to be used by Pediatric Therapy Center, for the purpose of training other professionals or paraprofessionals.
_____ I give permission for my child's picture/video to be used by Pediatric Therapy Center, for marketing/publicity.
_____ I do not wish my child's picture/video to be used for any purpose other than training his/her specific clinical team.
_____ I do not give permission for any photos/video to be taken of my child

Consent to Release/Receive Medical Information:

We understand the importance of coordinating and communicating with other persons involved in your child's development. We encourage you to provide us with contact information of other professional(s) working with your child.
I agree to let Pediatric Therapy Center, to share and receive information from other agencies (organizations) about my child so services can be coordinated and optimized for my child's benefit. The following organizations are included in this release:

Medical Professionals:
_____
Schools/Teachers:
_____
Other:_____