Therapy Connections
17081 E. Cherry Bend Rd.
Traverse City, MI 49684
616-46-4360

Client Name:_____Age:_____ DOB:_____
Date:_____Referred by:_____

Parent Information: Are parents married? Yes or No
Mother's Name:_____Occupation:_____
Address:_____
Cell Phone:_____Email:_____

Father's Name:_____Occupation:_____
Address:_____
Cell Phone:_____Email:_____

Siblings in household:
Name and Age:_____
_____
Primary reason for appointment:_____
_____
When were these concerns first noticed?_____
Have you been to your pediatrician or other practitioner regarding above issue?_____
_____
Have you done any therapies/treatments for above issue?_____
_____
Name of Pediatrician:_____
Does your child have a medical diagnosis?_____
Is your child on any medications/supplements?_____
Are there any precautions/allergies therapist should be aware of?_____
_____
Is there any recent crisis or stress going on that is important to your child's development?
_____
Is there a history of Trauma?_____
_____

Client Birth History:
Is child Adopted? Yes or No Location adopted from:_____

Pregnancy: Were there any complications: illness/infections/stress/bedrest/diabetes
_____
_____
Length of pregnancy: premature/full term/post mature (circle one)
Medications taken during pregnancy?_____

Delivery: Child's Birth Weight:_____

Were there any complications during labor and delivery?_____
_____
Length of Labor:_____Induced Labor? Yes or No
Breech_____Vaginal_____C-section_____Forceps:_____Vacuum:_____
Were there any problems after delivery? (jaundice/tube feedings/oxygen)
_____
_____
Did baby feed right away? Yes or No Breast or Bottle
Any problems with feeding or respiration the first month weeks of life? Yes or No
_____

Health History:
Does child have any illnesses or recurring health issues?_____
_____
Any hospitalizations or surgeries?_____
_____
Any high fevers/convulsions/seizures?_____
A history of ear infections? Yes or No Frequency:_____Ear tubes:_____

Developmental History:
Circle those that describe your **infant:**
Fussy/irritable Quiet Active Resisted being held Tense Passive
Irregular sleep patterns Slept well Liked being held Floppy
Non-demanding Floppy

Check those that describe your child at **present:**

Postive self esteem	Usually happy
Mostly quiet/shy	Overly active
Tires easily	Talks constantly
Restless	Stubborn
Difficulty separating from parents:	Fights frequently
	Clumsy
Over-reacts	Nervous habits/tics
Frequent temper tantrums	Poor attention span
Resists change	Distractible
Falls often	Sensitive
Easily frustrated	Has difficulty learning new tasks
Cries often	Impulsive

Comments:_____
_____
Milestones: Please write approximate age when your child did the following:
Raised Head:_____Sat:_____Rolled:_____
Crawled:_____Pulled to stand:_____Walked:_____
Spoke first word:_____Talked:_____Is speech clear to others? Yes or No

How would you describe your child's gross motor skills?
Jumping/Hopping/Skipping Poor Fair Good

Throwing/kicking/Catching balls Poor Fair Good
Fine motor Skills: Beading/lacing/scissors/coloring Poor Fair Good
Does your child like to do crafts and projects: Yes or No

Self Care Skills:
Sleeping: Do you have concerns with your child's sleep habits? Does he have a hard time falling asleep/staying asleep/waking too early/light sleeper/messy sleeper?
_____
Feeding:
Do you have concerns with feeding?_____
_____
Is your child a picky eater? Yes or No
Please give example of typical 3-day menu_____
_____
_____
_____
_____
_____
Does child self feed?_____What type of cup:_____
Is your child a messy eater? Yes or No

Dressing:
Do you have concerns with dressing?_____
_____
Can child get dressed by himself? Yes or No
Does your child not like certain clothing or tight clothing?_____
_____
Can child manipulate buttons, zippers, tie shoes?_____
_____

Bathing:
Do you have concerns with bathing?_____
_____
Does your child take baths or showers? Does he enjoy it?_____
Is he sensitive to temperature of water?_____
Is he sensitive to getting hair washed?_____

Toilet Training:
Is child toilet trained? Yes or No What age?_____Bed wetter:_____
Does your child have regular, daily bowel movements? Y or N
Color and Shape:_____
Any concerns:_____
_____

Play Skills:
What does your child do at home in regards to play?_____
_____

Any concerns socially?_____
Does child have playdates?_____
Does child participate in sports or after school programs?_____
_____
How much exercise per day does your child get? _____Type of Exercise:_____
_____
How much electronic time including t.v./computer/Ipad/phone does your child get daily?
_____
Is your child able to transition from screen?_____

Behavior/Regulation:
How long does it take your child to recover from significant upset?_____
Does your child have tantrums or "shut downs" for extended period of time over small problems? Yes/No
Does your child become aggressive when upset (kicking, hitting or throwing)? Yes/No
Is your child controlling with adults? Yes or No With Peers? Yes/No
Does your child have difficulty understanding others perspectives? Yes/No
Does your child appear to misinterpret social cues or interactions? Yes/No
Do the above behaviors happen at home/at school or in other environments? _____
_____
Does the child's behaviors negatively impact family dynamics and relationships? Yes/No
_____
Does the child's behaviors negatively impact social relationships and interactions? Yes/No_____
Does child's behaviors negatively limit his or her activities or environments? Yes/No
_____
Does your child have significant worries or fears that impact his daily routines? Yes/No

Miscellaneous:
Any sensitivities to sound, light, touch, motion sickness?_____
_____
Any difficulties attending birthday parties or other group or crowded situations?____
_____

School History:
What school does your child attend?_____
Does child like school? Yes or No Has child repeated grade? Yes or No
Is child in special education or receive any other services at school?_____
_____
Any concerns with academics?_____
Any concerns with homework?_____
Any concerns with handwriting?_____
Does your child have hard time paying attention or sitting still? _____

Any other concerns or issues that therapist should be aware of?_____
_____
_____

Any special interests or strengths that your child has that therapist should be aware of?
_____
_____

What are your goals for your child?_____
_____
_____

I give permission for Stacey Beyer, OTR/L of Therapy Connections TC to evaluate and treat my child.

Parent Signature:_____ Date: _____