KidSPOT pediatric therapies

Family Interview - OT

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Child's Name: _____ **DOB:** _____

Medical History

☐ Biological Child ☐ Adopted Child ☐ Foster Child

Were there any pregnancy or birth complications? ☐ Yes ☐ No

Describe: _____

Does your child have any of the following?

☐ Respiratory Conditions ☐ Cerebral Palsy ☐ Autism Spectrum Disorder
☐ Developmental Delay ☐ ADHD/ADD ☐ Genetic Syndromes
☐ Traumatic Brain Injury ☐ Orthopedic Injury ☐ Other Diagnoses: _____

Describe: _____

Medications/Vitamins:
1. _____ Purpose: _____
2. _____ Purpose: _____

ALLERGIES:

_____

Has your child had any of the following?

☐ X-Ray ☐ MRI ☐ Surgery
☐ Serious Illness ☐ Hospitalization ☐ Other Imaging

Describe (include approx. date): _____

☐ Chronic Ear Infections ☐ Vision Concerns ☐ Hearing Concerns

PE Tubes (age): _____ Test Results: _____

Digestion concerns (constipation, diarrhea, reflux)?

_____

Other Therapy or Specialist Services

Service: _____	Service: _____
Frequency: _____	Frequency: _____
Provider Name: _____	Provider Name: _____

Developmental Skills

DRESSING: ☐ Independent ☐ Needs Assistance ☐ Area of Concern
Current Skills: _____

GROOMING: ☐ Independent ☐ Needs Assistance ☐ Area of Concern
Current Skills: _____

BATHING: ☐ Independent ☐ Needs Assistance ☐ Area of Concern
Current Skills: _____

TOILETING: ☐ Independent ☐ Needs Assistance ☐ Area of Concern
Current Skills: _____

FEEDING: ☐ Independent ☐ Needs Assistance ☐ Area of Concern
Current Skills: _____

HANDWRITING: ☐ Independent ☐ Needs Assistance ☐ Area of Concern
Current Skills: _____

Daily Living Information

Child lives with: _____

Name of School/Daycare: _____ Grade: _____

Teacher: _____ Hours: _____

Does your child participate in any sports or regular physical activity? ☐ Yes ☐ No

Is your child over/under sensitive to any textures, flavors, sounds, or scents? ☐ Yes ☐ No

Does your child have trouble falling asleep, staying asleep or waking up? ☐ Yes ☐ No

If yes to any question above, please describe: _____

_____

Therapy Goals

Child's Strengths/Interests: _____

Goals for Therapy: _____

Anything else we should know to better serve you and your child? _____

_____