SEVENBRIDGES THERAPY

# Occupational Therapy Application

**For admin use only:**

**TODAY'S DATE:** _____

## CLIENT INFORMATION

Name (first/last): _____ Gender: ☐ M ☐ F DOB (mm/dd/yy): _____

Referred By: _____ Age (yrs/mo): _____

Services requesting or referred for:

☐ Social Group Therapy ☐ Individual Social Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Evaluation ☐ Screening ☐ Consultation

*****Requested/recommended service may change based on child's most immediate needs*****

**Describe any general concerns you have regarding your child**: _____

_____

_____

## PARENT/GUARDIAN INFORMATION

Primary Contact (first/last): _____ Relation to Client: _____

Address:_____

☐ Cell: _____ ☐ Work: _____ ☐ Email: _____

Second Contact (first/last): _____ Relation to Client: _____

☐ Cell: _____ ☐ Work: _____ ☐ Email: _____

List other caregivers that are permitted to participate in drop off, pick up, and wrap-ups:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

## BILLING INFORMATION *required*

**PARENTS**

*Email: _____ **all invoices are sent by email*

Address: _____City: _____ State: _____ Zip: _____

**INSURANCE**

Insurance Company name and Phone Number:_____

Member ID:_____

## REGIONAL CENTER CLIENTS *If you are not a Regional Center client skip to SCHEDULE AVAILABILITY section*

Have you spoken with your Case Manager about CW Services? ☐ Yes ☐ Not Yet

Case Manager (first/last): _____ Phone: _____

## SCHEDULE AVAILABILITY

List, for each day of the week, the blocks of time you are **available** to participate in therapy. Write *NA* on days that will not work for you.

| Hours of Operation: | | Your availability |
|---|---|---|
| 8am to 7pm | Monday | |
| | Tuesday | |
| | Wednesday | |
| | Thursday | |
| | Friday | |
| 8am to 4pm | Saturday | |

## BIRTH HISTORY

Birth Weight: _____lbs. _____ oz. Number of days' baby was in hospital after delivery: _____

Were there complications during (check all that apply):

☐ Pregnancy ☐ Delivery ☐ Post-Delivery OR ☐ Normal/ No Complications

If complications, briefly describe (e.g. weak suck nursing, vomiting, diarrhea, infections, low muscle tone):

_____

## FAMILY HISTORY/ENVIRONMENT

List language(s) spoken at home: _____

Child is: ☐ Biological ☐ Foster ☐ Adopted At what age? _____

Child resides with (check all that apply):

☐ Biological Mother ☐ Foster Mother(s) ☐ Adoptive Mother(s)

☐ Biological Father ☐ Foster Father(s) ☐ Adoptive Father(s) ☐ Other:_____

List sibling name(s), ages(s), and if they have medical, social, or academic concerns:

| Name | Age | Concerns (if applicable) |
|---|---|---|
| | | |
| | | |
| | | |

List any family members who have medical, physical, speech/language, social, academic, or learning challenges:

| Relation to Client | Concern(s) |
|---|---|
| | |
| | |
| | |
| | |

## MEDICAL HISTORY

History of medical concerns (check all that apply):

☐ Feeding Problems ☐ Eye Problems ☐ Head Trauma ☐ High Fever
☐ Tonsillitis ☐ Chronic Colds/Respiratory Infections ☐ Allergies ☐ Asthma
☐ Chronic Ear Infections ☐ Hearing Impairment ☐ Temporary Hearing Loss
☐ Other: _____

Diagnoses (e.g., autism, social anxiety, attachment disorder, attention deficit disorder, cerebral palsy, sensory processing disorder):

_____

Pediatrician: _____ last seen: _____

Hearing test: ☐ Yes ☐ No If yes, when? _____ results: _____

Vision test: ☐ Yes ☐ No If yes, when? _____ results: _____

List current medications: _____

List past medications: _____

List food allergies: _____

List special diet/dietary restrictions: _____

## EDUCATION *If your child is not currently in school skip to CURRENT SERVICES section*

Current School: _____ District: _____ Grade: _____

Type: ☐ Preschool ☐ Regular Ed ☐ Special Ed ☐ Special Day Class
☐ Other _____ ☐ Aide ___% of school day

How is your child doing academically? ☐ Excellent ☐ Satisfactory ☐ Poor

List any concerns your child's teacher has expressed to you: _____

_____

I give consent for Communication Works staff to speak with my child's current teacher. ☐ Yes ☐ No

Teacher (first/last): _____ Phone: _____

## CURRENT & PAST SERVICES *If your child has never received therapy services skip to DEVELOPMENT section*

Please list all past and/or current therapy services your child has received.

| Therapy Type & Location | Therapist (first/last) | Session Frequency | Last seen |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Current Therapy Goals: _____

_____

## DEVELOPMENT

I've noticed my child has/is (check all that apply):

- ☐ Not cooing or babbling
- ☐ Frequent hospitalization
- ☐ Resistant to cuddling
- ☐ Difficult to calm
- ☐ Colicky
- ☐ Separation anxiety from a parent
- ☐ Avoiding eye contact
- ☐ Nonresponsive when spoken to
- ☐ Unusual play methods
- ☐ Not gesturing (e.g., waving bye bye)
- ☐ Not pointing or requesting
- ☐ Restless
- ☐ Inactive
- ☐ Difficulty sharing
- ☐ Difficulty sleeping
- ☐ Difficulty eating

Did your child reach the following milestone at the typical age?

| **Milestones** | **Age in months** | **Yes** | **No** | **If No, then at what age?** |
|---|---|---|---|---|
| Pointed | 6 – 9 | ☐ | ☐ | _____ |
| Smiled | 3 – 6 | ☐ | ☐ | _____ |
| Sat without support | 6 – 8 | ☐ | ☐ | _____ |
| Crawled | 8 – 13 | ☐ | ☐ | _____ |
| Walked with assistance | 12 – 15 | ☐ | ☐ | _____ |
| Spoke first words | 12 | ☐ | ☐ | _____ |
| Spoke in 2 - 3 word sentences | 18 | ☐ | ☐ | _____ |
| Eating with fingers | 7 – 9 | ☐ | ☐ | _____ |
| Using cup/spoon | 18 – 24 | ☐ | ☐ | _____ |
| Sipped from open cup | 24 – 36 | ☐ | ☐ | _____ |
| Potty trained during day | 24 – 36 | ☐ | ☐ | _____ |
| Dressed self & fasteners | 42 – 48 | ☐ | ☐ | _____ |
| Bathed self | 72 - 78 | ☐ | ☐ | _____ |
| Brushed teeth | 72 - 78 | ☐ | ☐ | _____ |

Does your child (check all that apply):

- ☐ Repeat sounds, words, or phrases over and over
- ☐ Follow simple directions
- ☐ Understand what you are saying
- ☐ Retrieve/point to common objects when requested
- ☐ Respond correctly to who/what/when questions
- ☐ Respond correctly to yes/no questions

How does your child currently communicate?

- ☐ Body Language
- ☐ Sounds (vowels, gurgling)
- ☐ Words (shoe, doggy)
- ☐ 2 - 4 word sentences
- ☐ Sentences longer than 4 words
- ☐ Other: _____

At what age did you first become concerned about your child's physical, speech, language, and/or communication skills and why?

_____

_____

_____

In order to provide our therapists with a complete profile of your child's strengths and challenges, please check all that apply:

| **Attention** | Often | Sometimes | Rarely |
|---|---|---|---|
| Has difficulty sustaining attention in tasks or play activities in school or at home. | ☐ | ☐ | ☐ |
| Often fails to give close attention to details, or makes careless mistakes in schoolwork, work, or in other activities. | ☐ | ☐ | ☐ |
| Has difficulty organizing tasks and activities. | ☐ | ☐ | ☐ |
| Often loses things necessary for tasks and activities (e.g., toys, school assignments, pencils, books, tools, etc.). | ☐ | ☐ | ☐ |
| Fidgets with hands, or feet, or squirms in seat. | ☐ | ☐ | ☐ |
| Leaves seat in classroom, or in other situations in which remaining seated is expected. | ☐ | ☐ | ☐ |
| Daydreams and/or inattentive/loses focus easily. | ☐ | ☐ | ☐ |

| **Tactile (Touch)** | Often | Sometimes | Rarely |
|---|---|---|---|
| Reacts emotionally or aggressively to touch. | ☐ | ☐ | ☐ |
| Pinches, bites or hurts him/herself or others. | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| Frequently bumps or pushes others. | ☐ | ☐ | ☐ |
| Has unusually high pain tolerance. | ☐ | ☐ | ☐ |

| **Tactile (Touch) cont.** | Often | Sometimes | Rarely |
|---|---|---|---|
| Unusual clothing preferences (i.e., bothered by tags on cloths, clothes tight/lose, aversion to fabrics) | ☐ | ☐ | ☐ |
| Dislikes grooming tasks (i.e., hair washed/cut, nails cut, brushing teeth, etc.). | ☐ | ☐ | ☐ |
| Likes the feeling of sand, mud, or clay on hands/feet. | ☐ | ☐ | ☐ |
| Doesn't seem to notice when face or hands are messy (e.g., with food, drool, mucus, etc.). | ☐ | ☐ | ☐ |

| **Vestibular (Movement)** | Often | Sometimes | Rarely |
|---|---|---|---|
| Likes going fast on swings or slides more than other children. | ☐ | ☐ | ☐ |
| Gets nauseated, carsick and/or vomits easily. | ☐ | ☐ | ☐ |
| Has fear of falling or of heights (i.e. stairs, jumping, etc.). | ☐ | ☐ | ☐ |
| Loses balance easily. | ☐ | ☐ | ☐ |
| Enjoys being upside-down (somersaults, hanging from legs). | ☐ | ☐ | ☐ |
| Seems to be constantly on the move. | ☐ | ☐ | ☐ |
| Dislikes activities where head is upside-down. | ☐ | ☐ | ☐ |

| **Proprioceptive** | Often | Sometimes | Rarely |
|---|---|---|---|
| Seeks out roughhousing, jumping, or crashing games. | ☐ | ☐ | ☐ |
| Tends to get too close to people and invades their physical space. | ☐ | ☐ | ☐ |
| Poor body awareness- doesn't know where body parts are. | ☐ | ☐ | ☐ |
| Bumps into classmates, furniture, walls, etc. | ☐ | ☐ | ☐ |
| Difficulty grading force on objects (i.e. breaks crayons, pencil points, toys etc.). | ☐ | ☐ | ☐ |
| Chews on non-food items (e.g., pencils, shirt, hair). | ☐ | ☐ | ☐ |

| **Visual** | Often | Sometimes | Rarely |
|---|---|---|---|
| Has difficulty tracking objects with eyes (e.g., reading, hand-eye coordination). | ☐ | ☐ | ☐ |
| Has difficulty copying words from the board. | ☐ | ☐ | ☐ |
| Difficulty putting together age appropriate puzzles. | ☐ | ☐ | ☐ |
| Makes reversals when copying or reading. | ☐ | ☐ | ☐ |
| Becomes frustrated finding something in a cluttered drawer. | ☐ | ☐ | ☐ |
| Bothered by bright lights. | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| Distressed in crowded or busy settings (e.g., grocery store, parties). | ☐ | ☐ | ☐ |

| **Taste and Smell** | Often | Sometimes | Rarely |
|---|---|---|---|
| Is an extremely picky eater. | ☐ | ☐ | ☐ |
| Has difficulty eating various textured foods. | ☐ | ☐ | ☐ |
| Has sensitivity to smells and/or tastes (e.g., glue, markers, food). | ☐ | ☐ | ☐ |
| Tastes or smells objects when playing with them. | ☐ | ☐ | ☐ |
| Prefers spicy, sour, or bitter food flavors. | ☐ | ☐ | ☐ |

| **Auditory (Sound)** | Often | Sometimes | Rarely |
|---|---|---|---|
| Shows difficulty/bothered by loud sounds, may cover ears. | ☐ | ☐ | ☐ |
| Responds negatively to unexpected noises. | ☐ | ☐ | ☐ |
| Bothered by background sounds (e.g. refrigerator, fluorescent lights, fans) when trying to concentrate. | ☐ | ☐ | ☐ |
| Appears hard of hearing or deaf at times (e.g. doesn't respond to name) although hearing is intact. | ☐ | ☐ | ☐ |
| Likes to play or make music at loud volumes. | ☐ | ☐ | ☐ |
| Hums, repeats verbal information, or makes noises with mouth. | ☐ | ☐ | ☐ |

| **Coordination/Balance/Muscle Control (Fine/Gross Motor Skills)** | Often | Sometimes | Rarely |
|---|---|---|---|
| Slouches when sitting on floor/chair. Muscles feel tight or very loose. | ☐ | ☐ | ☐ |
| Seems generally weak compared to same-age peers. | ☐ | ☐ | ☐ |
| Poor rhythm, coordination when jumping/clapping. | ☐ | ☐ | ☐ |
| Sat, stood, or walked late. | ☐ | ☐ | ☐ |
| Has difficulty with sequential tasks (e.g., dressing, buttoning, zipping). | ☐ | ☐ | ☐ |
| Gets tired easily when playing on playground equipment. | ☐ | ☐ | ☐ |
| Has difficulty holding a pencil or crayon in a 3-point position (after age 5). | ☐ | ☐ | ☐ |
| Seems clumsy or awkward. | ☐ | ☐ | ☐ |
| Does not have a dominant hand (after age 5). | ☐ | ☐ | ☐ |
| Has difficulty using both hands together (e.g., opening milk carton, cutting, catching with two hands). | ☐ | ☐ | ☐ |
| Unable to ride a bike, tricycle, or big wheel. | ☐ | ☐ | ☐ |
| Unable to tie shoelaces. | ☐ | ☐ | ☐ |

| **Behavior/Temperament/Regulation** | Often | Sometimes | Rarely |
|---|---|---|---|
| Quiet, calm, relaxed, patient | ☐ | ☐ | ☐ |
| Active, outgoing, enthusiastic | ☐ | ☐ | ☐ |
| Intense, demanding | ☐ | ☐ | ☐ |
| Hyperactive, in perpetual motion | ☐ | ☐ | ☐ |
| Upset by transitions or unexpected changes. | ☐ | ☐ | ☐ |
| Exhibits frequent temper tantrums. | ☐ | ☐ | ☐ |
| May run or hide if upset. | ☐ | ☐ | ☐ |
| May yell or hit when upset. | ☐ | ☐ | ☐ |
| Becomes easily frustrated. | ☐ | ☐ | ☐ |
| Passive, quiet, withdrawn | ☐ | ☐ | ☐ |
| Rigid, set in his/her ways, inflexible. | ☐ | ☐ | ☐ |
| Irregular sleep patterns | ☐ | ☐ | ☐ |
| Irrational when presented with a problem, unable to determine the size of the problem. | ☐ | ☐ | ☐ |
| Cranky, grouchy, irritable even when not frustrated. | ☐ | ☐ | ☐ |
| Sad, fatigued, tired, low energy. | ☐ | ☐ | ☐ |
| Anxious, nervous, worried, fearful. | ☐ | ☐ | ☐ |
| Impulsive or acts without thinking. | ☐ | ☐ | ☐ |
| Has nervous habits or tics. | ☐ | ☐ | ☐ |
| Has difficulty accepting limits: argues or debates rather than comply | ☐ | ☐ | ☐ |

| **Executive Functioning Skills** | Often | Sometimes | Rarely |
|---|---|---|---|
| Has trouble keeping personal space neat/organized (e.g., desk, room). | ☐ | ☐ | ☐ |
| Shows limited ability to learn from past experiences. | ☐ | ☐ | ☐ |
| Perseverative, has difficulty initiating or inhibiting a shift in behavior or thought. | ☐ | ☐ | ☐ |
| Limited ability to self-soothe: use self-talk and tension reducing activities to cope with frustration. | ☐ | ☐ | ☐ |
| Has difficulty previewing: foreseeing possible problems or conflicts. | ☐ | ☐ | ☐ |
| Has difficulty participating in family routines and responsibilities. | ☐ | ☐ | ☐ |
| Shows dependence on their caretakers to help them achieve age appropriate self care. | ☐ | ☐ | ☐ |
| Has difficulty envisioning a goal or outcome. | ☐ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| Has difficulty making and following a plan to achieve a desired outcome. | ☐ | ☐ | ☐ |
| Overestimates/underestimates his/her abilities and skills. | ☐ | ☐ | ☐ |