



## PARTICIPANT'S APPLICATION AND HEALTH HISTORY

(To be completed by the participant's parent/legal guardian.)

### GENERAL INFORMATION

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School grade: \_\_\_\_\_

Receive therapy at school? Y or N (*circle all that receive*) PT OT Speech

(*Circle one*) On an IEP or 504 plan?

(*Circle one*) Biological Adopted Foster Age at the start of Foster/Adopt? \_\_\_\_\_

### HISTORY

Diagnosis:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Medications (and reason for taking):

1. \_\_\_\_\_ 2. \_\_\_\_\_ 2. \_\_\_\_\_  
\_\_\_\_\_ 4. \_\_\_\_\_

### BIRTH HISTORY (*Please circle and complete, as applicable,*)

On time delivery? Y or N If *no*, # weeks early? \_\_\_\_\_

Type of delivery: Vaginal or C-section

Complications: NICU stay? Y or N If *yes*, how many days/weeks in hospital? \_\_\_\_\_

Early Intervention: Y or N If *yes*, what type of therapy and for how long? \_\_\_\_\_

Feeding Issues: Y or N If *yes*, explain: \_\_\_\_\_  
\_\_\_\_\_

**SURGICAL HISTORY**

**DEVELOPMENTAL HISTORY:**

**Milestones:** (circle *Yes/No* re: ability to do task & add approximate age they achieved skill, if you remember)

Held head up: Y or N \_\_\_\_\_ Hands to midline: Y or N \_\_\_\_\_

\_\_\_\_\_ Looked at hands: Y or N \_\_\_\_\_

\_\_\_\_\_ Held bottle or toy to mouth: Y or N \_\_\_\_\_

\_\_\_\_\_ Mouthed hands and objects: Y or N \_\_\_\_\_

\_\_\_\_\_ Rolled each direction: Y or N \_\_\_\_\_

\_\_\_\_\_ Able to sit up by themselves: Y or N \_\_\_\_\_

\_\_\_\_\_ Appropriate eye contact: Y or N \_\_\_\_\_

\_\_\_\_\_ Pulled to stand: Y or N \_\_\_\_\_

\_\_\_\_\_ Crawled: Y or N \_\_\_\_\_

Able to pick up small objects, such as small pieces of food items? Y or N \_\_\_\_\_ Able to walk: Y or N \_\_\_\_\_

\_\_\_\_\_ Able to hop on 2 feet: Y or N \_\_\_\_\_ Hop on one foot: Y

or N \_\_\_\_\_

**Sleep/Wake Cycle:**

Slept through night Y or N If yes, at \_\_\_\_\_ # months Needs extra help to get to sleep: Y or N If *yes*,

what? \_\_\_\_\_ Sleeps in own bed: Y or N If *no*, where?

\_\_\_\_\_ Wakes in middle of night: Y or N If *yes*, will child return to sleep?

**Additional Feeding Info., (if appropriate):**

Sensory Issues w feeding: Y or N If *yes*, what type? \_\_\_\_\_ Eats adequate variety

by mouth: Y or N If *no*, are they G-tube fed? Y or N If *G-tube fed*: What % of calories thru tube?

\_\_\_\_\_ %

What % of hydration thru tube? \_\_\_\_\_ %

Hyperactive gag reflex: Y or N \_\_\_\_\_

Messy eater: Y or N \_\_\_\_\_

Able to use utensils correctly: Y or N If *no*, describe? \_\_\_\_\_ Able to drink from open cup: Y or N Uses Sippy/Tippy? Y or N Bottle/Breastfed (*circle*) **Sensory Issues:**

Sensitive to touch: Y or N \_Ex. \_\_\_\_\_ Sensitive to sounds: Y or N \_Ex. \_\_\_\_\_ Movement/Energy Level differences:

\_\_\_\_\_ Body Awareness issues: Y or N \_Ex. \_\_\_\_\_

(*ex. Are they aware if face is messy, clumsy, too close to others, bumps into things, toe walker*) Sensitive to visual stimuli: Y or N \_Ex. \_\_\_\_\_ (*ex. Do they seek visual input, covers eyes, stares at fan/moving strings, flaps hands in front of face*)

**Cognitive, Self-Regulation, Attention and Executive Function struggles/differences:** Y or N (*Are they aware of time, manners, non-verbal communication? Have issues with sequencing, learning new tasks, difficulty remembering rules, difficulty w play skills and socialization; impulsive, frustrated easily, difficulty completing chores; frequent and exaggerated/long tantrums; self-injurious/aggressive toward others*)

**Self-Care Difficulties:** (*circle one*)

**Dressing:** Can do by themselves Need a little help Need a lot of help Need total assistance **Bathing:** Can do by themselves Need a little help Need a lot of help Need total assistance **Grooming:** Can do by themselves Need a little help Need a lot of help Need total assistance **Hygiene:** Can do by themselves Need a little help Need a lot of help Need total assistance **Toileting:** Can do by themselves Need a little help Need a lot of help Need total assistance **Brush Teeth:** Can do by themselves Need a little help Need a lot of help Need total assistance **Transfers:** Can do by themselves Need a little help Need a lot of help Need total assistance **Walking:** Can do by themselves Need a little help Need a lot of help Need total assistance

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**Adaptive or special equipment:**

Vision concerns: Y or N Glasses: Y or N

Hearing concerns: Y or N Hearing Aides: Y or N

*(Circle, if use/d:) AFOs, special needs stroller, wheelchair, splints, helmet, walker, hospital bed, oxygen at night*

**Psycho/Social Function:** *(i.e. Work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)*

**Goals** *(i.e. What would you like your child to accomplish or improve in?)*

**Additional Comments/Concerns**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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