Reigning Hope Therapy Services

Farm Clinic

PARTICIPANT'SAPPLICATIONAND 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 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? _____

Early 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 w 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

_____

_____

_____

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:*) 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 for your child to accomplish or improve in?)*

_____

_____

_____

_____

Additional Comments/Concerns

_____

_____

_____

_____

Signature: _____ Date:_____

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