

PARTICIPANT'SAPPLICATIONAND HEALTH HISTORY

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

GENERAL INFORMATION	
Participant Name:	

Participant Name: _		Date of Birth:	
School grade:		_	
Receive therap	y at school? Y or N	(circle all that receive) PT OT Speech	
(Circle one)	On an IEP or 504 plan?	2	
(Circle one)	Biological Adopted I	Foster Age at start of Foster/Adopt?	
HISTORY			
Diagnosis:			
1	2	34	
Medications (and rea	son for taking):		
1		2	
2		4	
BIRTH HISTORY	<u>(Please circle and com</u>	nplete, as applicable,)	
On time delivery?	Y or N	If <i>no</i> , # weeks early?	
Type of delivery:	Vaginal or C-section		
Complications: NIC	CU stay? Y or N	If yes, how many days/weeks in hospital?	-
Early Intervention:	Y or N	If <i>yes</i> , what type of therapy and for how long?	_
Early Feeding Issue	s: Y or N	If <i>yes</i> , explain:	_

DEVELOPMENTAL HISTORY:

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

l head up:	Y	or	Ν	_	
ds to midline:	Y	or	N		
ked at hands:	Y	or	N	_	
bottle or toy to mouth:	Y	or	N	-	
thed hands and objects:	Y	or	N	-	
ed each direction:	Y	or	N	Ι_	
to sit up by themselves:	Y	or	N	_	
ropriate eye contact:	Y	or	N	_	
ed to stand:	Y	or	N	_	
vled:	Y	or	N		
to pick up small objects, su	ıch	as s	mal	l pi	ieces of food items? Y or N
e to walk:	Y	or	N	_	
to hop on 2 feet:	Y	or	N	[_	Hop on one foot: Y or N
<u>ke Cycle:</u>					
t through night		Y	or	N	I If yes, at# months
ds extra help to get to sleep:		Y	or	N	If yes, what?
ps in own bed:		Y	or	N	If <i>no</i> , where?
es in middle of night:		Y	or	N	N If yes, will child return to sleep?
al Feeding Info., (<i>if approp</i>	<u>ria</u>	<u>te):</u>			
ory Issues w feeding:	•	Y	or	N	If yes, what type?
adequate variety by mouth:		Y	or	N	If <i>no</i> , are they G-tube fed? Y or N
If G-tube fed: W	'hat	%	of ca	aloı	ries thru tube?%
W	'hat	%	of hy	ydr	ration thru tube?%
eractive gag reflex:	Ţ	7	or	N	
	ds to midline: ted at hands: bottle or toy to mouth: thed hands and objects: ed each direction: to sit up by themselves: ropriate eye contact: ed to stand: vled: to pick up small objects, su to walk: to hop on 2 feet: ke Cycle: t through night ds extra help to get to sleep: ps in own bed: es in middle of night: h Feeding Info., (<i>if approp</i> ory Issues w feeding: adequate variety by mouth: If <i>G-tube fed</i> : W	ds to midline: Y de to midline: Y teed at hands: Y bottle or toy to mouth: Y thed hands and objects: Y ed each direction: Y ed each direction: Y to sit up by themselves: Y ropriate eye contact: Y ed to stand: Y vled: Y to pick up small objects, such to walk: Y to hop on 2 feet: Y ke Cycle: t through night ds extra help to get to sleep: ps in own bed: es in middle of night: d Feeding Info., (<i>if appropriat</i> ory Issues w feeding: A adequate variety by mouth: Y If <i>G-tube fed</i> : What What	ds to midline: Y or and at hands: Y or bottle or toy to mouth: Y or thed hands and objects: Y or ed each direction: Y or et o sit up by themselves: Y or ropriate eye contact: Y or ed to stand: Y or et o pick up small objects, such as se to walk: Y or e to hop on 2 feet: Y or ke Cycle: t through night Y ds extra help to get to sleep: Y ps in own bed: Y es in middle of night: Y hereding Info., (<i>if appropriate</i>): ory Issues w feeding: Y adequate variety by mouth: Y If <i>G-tube fed</i> : What % or What %	ds to midline: Y or N teed at hands: Y or N teed at hands: Y or N bottle or toy to mouth: Y or N thed hands and objects: Y or N ed each direction: Y or N to sit up by themselves: Y or N to sit up by themselves: Y or N to stand: Y or N ed to stand: Y or N ed to stand: Y or N te to pick up small objects, such as small to walk: Y or N to on pon 2 feet: Y or N to hop on 2 feet: Y or N through night Y or ds extra help to get to sleep: Y or ps in own bed: Y or es in middle of night: Y or d Feeding Info., (<i>if appropriate</i>): ory Issues w feeding: Y or adequate variety by mouth: Y or If <i>G-tube fed</i> : What % of ca What % of hy	ds to midline: Y or N

Messy eater:	Y	or	Ν	
Able to use utensils correctly:	Y	or	Ν	If <i>no</i> , 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 diffe	erence	s: _		
Body Awareness issues:	Y	or	N	_Ex
(ex. Are they aware if fa	ice is i	mess	y, clı	umsy, too close to others, bumps into things, toe walker)
Sensitive to visual stimuli:	Y	or	Ν	_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)

<u>Self-Care Difficulties: (circle one)</u>

Dressing:	Can do by themselves	Ν
Bathing:	Can do by themselves	N
Grooming:	Can do by themselves	N
Hygiene:	Can do by themselves	N
Toileting :	Can do by themselves	N
Brush Teeth	Can do by themselves	N
Transfers:	Can do by themselves	N
Walking:	Can do by themselves	N

Need a little help Need a lot of help Need total assistance Need total assistance

Adaptive or special equipment:

Vision concerns:	Y	or	Ν	Glasses:	Y	or	Ν
Hearing concerns:	Y	or	Ν	Hearing Aides:	Y	or	Ν

(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.)

<u>Goals</u> (*i.e.* What would you like for your child to accomplish or improve in?)

Additional Comments/Concerns

Signature: _____ Date: _____

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