Pediatric Therapy Links, LLC

1151 SW 30th Street Suite E, Palm City, Florida 34990

Phone: (772) 291-2179 · Fax: (772)-600-8274 · info@pediatrictherapylinks.com

PATIENT REGISTRATION FORM – OCCUPATIONAL THERAPY

PATIENT NAME (LAST, FIRST)	D.O.B.	SOCIAL SECURITY NUMBER	SEX
ADDRESS: NUMBER & STREET APT#		CITY STATE ZIP CODE	
HOME PHONE		EMAIL ADDRESS	
REFERRED BY		PHYSICIAN PHONE NUMBER	
PEDIATRICIAN/PRIMARY CARE PHYSICIAN (PCP)		PCP PHONE NUMBER	

MOTHER/GUARDIAN NAME (LAST, FIRST)	D.O.B.	SOCIAL SECURITY NUMBER
ADDRESS: NUMBER & STREET APT#		CITY STATE ZIP CODE
HOME/CELL PHONE		EMAIL ADDRESS
FATHER/GUARDIAN NAME (LAST, FIRST)	D.O.B.	SOCIAL SECURITY NUMBER
ADDRESS: NUMBER & STREET APT#		CITY STATE ZIP CODE
HOME/CELL PHONE		EMAIL ADDRESS

PRIMARY INSURANCE	POLICYHOLDER'S NAME (LAST, FIRST)	RELATIONSHIP TO PATIENT
INSURANCE ID/POLICY NUMBER	GROUP NUMBER	
SECONDARY INSURANCE	POLICYHOLDER'S NAME (LAST, FIRST)	RELATIONSHIP TO PATIENT
INSURANCE ID/POLICY NUMBER	GROUP NUMBER	

I am an authorized beneficiary of the above insurance plan(s). I confirm that all of the above information is accurate and I agree to notify Pediatric Therapy Links, LLC of any changes.

_____ _____ _____

Parent/ Guardian Signature Date Relationship to Patient

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Patient Name: _____ **Patient DOB:** _____

CURRENT CONCERNS:

1. Please describe your specific concerns you have for your child related to his or her motor development, play skills, and/ or sensory processing skills:
   _____
   _____
   _____
   _____

2. Has your child had any occupational therapy evaluations within the past six months? If so, with what provider, what assessments were administered, and when was this assessment completed with your child?
   _____
   _____

3. When did you first notice a concern with your child's motor development or concerns with your child's sensory processing skills?_____

4. Has your child had a hearing test within the past year? _____

FAMILY BACKGROUND

1. What is the primary language spoken in the home?
   ☐ English ☐ Spanish
   ☐ Creole

2. What is your child's dominant language?
   ☐ English ☐ Spanish
   ☐ Creole

3. Please list any other children in the home.
   _____ (Age) _____ _____ (Age) ____
   _____ (Age) _____ _____ (Age) ____

4. Are there any family members or relatives who have or have had the same problem?
   ☐ No ☐ Yes If yes, who and please describe _____
   _____

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Patient Name: _____ **Patient DOB:** _____

BIRTH HISTORY

1. Were there any illnesses or complications during pregnancy with this child?
   ☐ No ☐ Yes If yes, please explain? _____
   _____
2. Pregnancy term and birth weight: ☐ Full Term ☐ If no, how many weeks? _____ Birth Weight ____
3. Delivery Method: Via ☐ Cesarean Section ☐ Vaginal ☐ Breach
4. Were there any drugs or medications taken during this pregnancy?
   ☐ No ☐ Yes If yes, please explain? _____
5. Were there any immediate problems following the birth or during the first 2 weeks of the infants life?
   ☐ No ☐ Jaundice ☐ Feeding ☐ Required Oxygen ☐ Sucking or swallowing problems
   ☐ Sleep Patterns ☐ Infant required a NICU stay (If so, how long and why?)_____
6. Develpmental Milestones:
   Babble/ Coo age _____
   Say first word age _____
   Put 2-3 words together age _____
   Speak in sentences age _____
   Sit alone age _____
   Crawl age _____
   Walk age _____

MEDICAL HISTORY:

1. How is your child's overall health? ☐ Good ☐ Fair ☐ Poor
2. Are immunizations up to date? ☐ Yes ☐ No
3. Does your child have any known allergies? ☐ None ☐ Yes If yes, please list: _____
   _____
4. List all medications and dosages currently prescribed to your child:

Medication	Dosage	Purpose

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Patient Name: _____ **Patient DOB:** _____

5. Does your child have a history of surgery or hospitalizations?
   ☐ No ☐ Yes (please explain) _____
   _____
6. Please check the following as they apply to your child:
   ☐ Autism/ PDD ☐ Down Syndrome ☐ Cerebral Palsy ☐ ADHD/ADD
   ☐ Dyslexia ☐ Hearing Loss ☐ Cognitive Impairment
   ☐ Psychological/ Behavioral Concerns ☐ None
7. Has your child had any of the following conditions?
   ☐ Asthma ☐ Low Birth weight ☐ Cleft Lip ☐ Cleft Palate
   ☐ Seizure ☐ Food Sensitivities ☐ Spinal Cord Injury ☐ Head Injury
   ☐ Adenoidectomy ☐ Tonsilitis ☐ Visual Impairments ☐ Hearing Impairments
8. Please describe any other relevant medical diagnoses: _____
   _____

SKILLS:

1. If your child is school age, how would you describe his/ her handwriting?
   ☐ Neat
   ☐ Sloppy
   ☐ Average
   ☐ N/A
2. Does your child engage in eye contact during communication?
   ☐ Yes
   ☐ Sometimes
   ☐ No
3. When given a choice, does your child prefer to play alone or with others?
   ☐ Alone
   ☐ With Others
4. Can your child TAKE OFF the following items independently (please check all that apply)?
   ☐ Socks
   ☐ Shoes
   ☐ Pants
   ☐ Shirt

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5. Can your child PUT ON the following items independently (please check all that apply)?
   - ☐ Socks
   - ☐ Shoes
   - ☐ Pants
   - ☐ Shirt

6. Please indicate if your child can do the following skills independently (please check all that apply):
   - ☐ Potty Trained
   - ☐ Wash Hands
   - ☐ Brush Teeth
   - ☐ Brush Hair
   - ☐ Get Dressed
   - ☐ Bathe/ Shower

7. Does your child have any sensory based concerns:
   - ☐ Sensitivity to Loud Noises or Sounds
   - ☐ Sensitivities to Textures (clothing and/ or food)
   - ☐ Picky Eater
   - ☐ Excessive Hand Movements
   - ☐ Avoiding Certain Activities
   - ☐ Becomes Easily Excited in Specific Situations

EDUCATIONAL BACKGROUND:

1. Please indicate the following:
   Name of your child's School:_____ Grade: _____
   Any grades repeated: _____ Type of Classroom: ☐ General Education ☐ ESE

2. Does your child have an IEP? ☐ No ☐ Yes, Program: _____

3. Please indicate any/ all areas of difficulty: ☐ Reading ☐ Writing ☐ Math ☐ Spelling ☐ Interacting

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BEHAVIORAL BACKGROUND:

Please check all that apply:

Behavior	Yes	No	Behavior	Yes	No
Friendly/ Outgoing			Mostly Quiet		
Is Usually Happy			Poor Memory		
Is impulsive/ restless			Poor turn taking		
Sleeping Difficulties			Difficulty concentrating		
Attentive			Lacks pretend play		
Cooperative			Avoids group play		
Eating Difficulties			Avoids eye contact		
Withdrawn			Recognized danger		
Destructive/ Aggressive			Overly Active		
Imitated actions/ speech			Plays with toys appropriately		
Difficulty separating			Difficulty with transitions		
Understands praise			Follows familiar commands		