Biographical and Developmental Information

Child's Name: ____________________ Date: _____ (Year) _____ (Month) _____ (Day)
Address: ____

Date of Birth: _____ (Year) _____ (Month) _____ (Day) Current Age: ______________
Phone (home): ____________________ Emergency #: ____________________

FAMILY INFORMATION:
Parent's Name: ____________________ Occupation: ____________________
Address: ____

Home Phone: ____________________ Cell/Work Phone: ________________
E-mail: ____

Parent's Name: ____________________ Occupation: ____________________
Address: ____

Home Phone: ____________________ Cell/Work Phone: ________________
E-mail: ____

Living Situation:
____

Siblings:
_____________________ Age: ________ Grade: ________
_____________________ Age: ________ Grade: ________
_____________________ Age: ________ Grade: ________

Current or ongoing concerns/reason for OT referral:
____
____

MEDICAL INFORMATION:
Physician: ____________________ **Diagnosis:** ____________________
Address: ____
Phone: ____________________

MOTHER'S HEALTH DURING PREGNANCY:
Please circle Yes or No to the following questions and remark in the space provided.
1. Were there any infections/illnesses during pregnancy? Yes No ____
2. Was there any unusual stress during pregnancy? Yes No ____
3. Were any drugs or medications taken during pregnancy? Yes No ____
4. Was the pregnancy full-term? Yes No If no, number of weeks gestation: ____
5. Was the labor normal? Yes No ____
6. Was the delivery normal? Yes No If no, please specify (e.g. cesarean section, breech, cord around neck, forceps used): ______________________

CHILD'S BIRTH:
Please circle all that apply and/or fill in the blanks.
1. Child's weight at birth: ____ Length of infant's hospital stay: ____________
2. Were there any complications? seizures jaundice congenital defects other: ________________
3. Was there a need for: oxygen transfusions tube feedings other: ____________________________
4. Did your infant cry right away? ____________ Apgar scores: 1 min ________ 5 min ________
5. Was the child breast fed or bottle fed? ________________ When weaned? ____
6. Did the infant have any feeding problems? ____
7. Describe your child's demeanor and behavior as an infant: ____
8. Please state any other difficulties or special concerns: ____

DEVELOPMENTAL MILESTONES:
Please list the age (in months) at which your child did the following and answer the questions that follow.
Roll ______ Sit ______ Belly crawl ______ Crawl on hands/knees ______ Walk ______ Stand ______
Run ______ Skip ______ Say first word _____ Finger feed ______ Use spoon/fork ______
Sleep Thru Night ______ Drink from cup ______ Dress independently __________
1. Any concerns or questions about your child's development? ____
____
2. When did your child gain bladder control? ___________ Bowel control? ____________

CURRENT CONDITION:
Please circle all that apply and/or fill in the blanks.
Date of last physical exam: ___________ Current weight: ___________ Current height: ____________
My child currently sleeps/naps: inconsistently well restless other
My child currently eats/drinks: at regular/ irregular intervals consistent/ inconsistent amounts
Known Allergies/Diet Restrictions:
____
____
Are immunizations up to date? Yes No ____
History of major illnesses/hospitalizations: ____
____
History of ear infections? Yes No If yes, how many: _________________________
Date of most recent hearing test: ____ Results: ____
Where was the test conducted? ____School ____Doctor ____Audiologist
Does your child wear hearing aids? Yes No Describe hearing loss:_________________________________
Date of most recent vision screening: ______ Results: _______________________________________
Please describe any vision impairment: ____
How does your child currently move in his/her environment?
____
Any diagnosed mental, physical or emotional disabilities?
____
Describe you child's current demeanor/behavior:
____
____

PREVIOUS & CURRENT THERAPIES AND/OR SPECIALISTS: please list names, types and dates seen. If applicable, please provide copies of relevant evaluations and reports (occupational therapy, speech-language therapy, psychoeducational, neurological, IEPs, etc.)
____
____
____
____
____
____
____
____

SOCIAL/EDUCATIONAL HISTORY:
School/Day Care: ____ Grade: _________________
Teacher's Name: ____ Phone: _________________
Activities your child enjoys at home or school: ____
____
____
Does your child prefer to do these activities alone or with other children/siblings? ___________________________
____
____
Are you confident your child's current school is meeting your child's needs? ___________________________
____

WHAT ARE THE THREE OR FOUR MOST IMPORTANT GOALS YOU WISH TO HAVE ADDRESSED DURING YOUR CHILD'S TREATMENT AT SPRING OCCUPATIONAL THERAPY INC?

____

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____

PLEASE USE SPACE BELOW or ON THE BACK OF THIS FORM FOR FURTHER COMMENTS ABOUT ANYTHING YOU THINK WE SHOULD KNOW ABOUT YOUR CHILD:

____

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____

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____

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____

200, 2115 Sirocco Drive SW | Calgary, AB T3H 5P1

cell: (403) 466.2052 | office: (403) 685.2893 | fax: (403) 685.2894 | web: www.springot.com

ACTIVITIES OF DAILY LIVING INDEPENDENCE CHECKLIST

On the following scale from 1-10 (one=low, 10=high), please rate the level of difficulty you/your child has with the following activities. When considering your answers, please do not compare your child to any other children, but simply give the answer that best describes how you see them doing in relation to what is expected of them in your home.

Activity										
Morning wake-up:	1	2	3	4	5	6	7	8	9	10
Brushing Teeth:	1	2	3	4	5	6	7	8	9	10
Washing face/hands:	1	2	3	4	5	6	7	8	9	10
Brushing hair:	1	2	3	4	5	6	7	8	9	10
Using toilet:	1	2	3	4	5	6	7	8	9	10
Choosing clothing:	1	2	3	4	5	6	7	8	9	10
Getting dressed:	1	2	3	4	5	6	7	8	9	10
Eating breakfast/meals	1	2	3	4	5	6	7	8	9	10
Gathering supplies for the day (books, lunch, etc.)	1	2	3	4	5	6	7	8	9	10
Doing homework:	1	2	3	4	5	6	7	8	9	10
Entertaining self:	1	2	3	4	5	6	7	8	9	10
Playing with others:	1	2	3	4	5	6	7	8	9	10
Helping with chores:	1	2	3	4	5	6	7	8	9	10
Mobility in the house:	1	2	3	4	5	6	7	8	9	10
Mobility entering/exiting the house:	1	2	3	4	5	6	7	8	9	10
Mobility getting in/out of the car:	1	2	3	4	5	6	7	8	9	10
Keeping track of belongings:	1	2	3	4	5	6	7	8	9	10
Getting ready for bed:	1	2	3	4	5	6	7	8	9	10
Falling asleep:	1	2	3	4	5	6	7	8	9	10
Staying asleep:	1	2	3	4	5	6	7	8	9	10

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DAILY ROUTINE/SCHEDULE

Please provide a general overview of a typical day in your child's life, keeping in mind the items included in the above activity checklist. This will help your child's therapist understand your child's experience and the potential challenges they may be encountering throughout the day.

5:00 a.m. –

6:00 a.m. –

7:00 a.m. –

8:00 a.m. –

9:00 a.m. –

10:00 a.m.

11:00 a.m. –

12:00 p.m. –

1:00 p.m. –

2:00 p.m. –

3:00 p.m. –

4:00 p.m. –

5:00 p.m. –

6:00 p.m. –

7:00 p.m. –

8:00 pm. –

9:00 p.m. –

10:00 p.m. –

11:00 p.m. –

12:00 p.m. –

Please provide any additional information re: your child's schedule/daily routines, i.e. school schedule, activities etc.

MONDAY:

TUESDAY:

WEDNESDAY:

THURSDAY:

FRIDAY:

WEEKENDS:

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Signature Form

Client Name: ______________________ **Date of Birth_________________**

Please review and sign the following:

Acknowledgement of Notice of Privacy Practices

I acknowledge that *Spring Occupational Therapy Inc.* will use and disclose my child's personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. I further acknowledge that *Spring Occupational Therapy Inc.* Notice of Privacy Practices, which is available at the initial appointment and/or upon request, provides further detailed information about how *Spring Occupational Therapy Inc.* may use and/or disclose protected medical information about my child for treatment, payment, healthcare operations, and as otherwise allowed by law.

_______________________________ _____________________

Client/Parent or Guardian Signature Date

Authorization to Release Medical Information

I hereby authorize *Spring Occupational Therapy* to communicate all aspects of my child's care with the physician(s) or other related professionals and significant others, whom I have identified.

Information can also be released to:

Pediatrician______________________________________

Other: ____

For the Purpose of:

Continued medical care/ Coordination of care

Insurance Claims

Legal Matters

Other: ______________________

This authorization is valid for the duration of my or my child's involvement with *Spring Occupational Therapy Inc.* from the date signed below. I understand that I may revoke this authorization at any time, but in doing so will not hold *Spring Occupational Therapy Inc.* responsible for already releasing information in good faith. *Spring Occupational Therapy Inc.* is released from legal responsibility or liability for the release of the above information to the extent indicated and authorized here.

_______________________________ _____________________

Client/Parent or Guardian Signature Date

Notice of Financial Responsibility

- **Client** is responsible for all evaluation, and scheduled session costs, regardless of insurance reimbursement.
- All clients and Agencies will be invoiced monthly and payment (check, e-transfer) is due 30 days from the date of invoice.
- **Client** is responsible for payment for any and all cancellations. Please see the cancellation charges section on your fee schedule for specific details. ***Spring Occupational Therapy Inc.*** does not submit claims for insurance reimbursement but we will do our best to answer any insurance-related questions. You are responsible for obtaining any pre-authorization, submitting your own invoices and any supporting paperwork, and following through with your insurance company regarding reimbursement for services or other questions. ***Spring Occupational Therapy Inc.*** cannot provide invoices to be used as claims for reimbursement until after your bill has been paid.

I have read the above and hereby accept all responsibility for evaluation and/or session costs provided to me or my child. The undersigned certifies that he/she has been explained the evaluation and consultation costs and is the responsible party and accepts these terms.

________________________________ _____________________

Responsible party and/or trustee of client's funds Date

Consent for Care and Intervention

As the client or child's parent/legal guardian, I hereby consent to necessary evaluation, procedures and/or interventions prescribed by my/my child's therapist at *Spring Occupational Therapy Inc.* as considered necessary in her or his judgment. I understand that various procedures and/or treatments may be used, and I further understand that *Spring Occupational Therapy Inc.* will make every effort to ensure that I or my child is safe during all procedures and/or treatments, but I acknowledge that injuries or accidents may occur. I expressly agree that *Spring Occupational Therapy Inc.* shall not be liable for any injuries or accidents sustained by me/my child while at *Spring Occupational Therapy Inc*. I understand that I/ my child is under the care and supervision of his/her therapist.

_____________________________________ _________________________
Client/Parent or Guardian Signature Date

Policy on Insurance Checks

Spring Occupational Therapy Inc. will not accept reimbursement checks received from your insurance company. I have read and understand the above.

_____________________________________ _________________________
Client/Parent or Guardian Signature Date

Photograph and Video Release Form

Spring Occupational Therapy Inc. is a private practice, focusing on assessment, consultations and treatments with children. Additionally, this practice is involved in the education of future therapists. As such, we may take photographs or videos of children or family members participating in services. The photographs and videos may include interviews, assessments, interventions, and/or other clinical activities. The rights, titles, and interests of these materials belong *to Spring Occupational Therapy Inc.* which reserves the right to edit the material.
I ____ (please print name) voluntarily consent to the taking of videos or photographs of myself or my child ____(print child's name).
I understand that these photographs or videos may be used for educational purposes, intervention purposes, and/or media purposes in educational training programs or media publications. I understand that the photographs or videos may be used to create educational training tapes and may be used by *Spring Occupational Therapy Inc.* seminars, staff/ student training or workshops. Some video or photographic material may be included in future training tapes. Specific names of children and other family members will not be used in photographs or videos.

I give permission for the use of photographs or videos for educational purposes, for news or other media and for training tapes.

__________________________________ _________________________
Parent or Guardian Signature Date

Electronic Communication

E-mail and electronic forms of communication are not necessarily confidential or secure. Your use of e-mail with *Spring Occupational Therapy Inc.* constitutes your acknowledgement of these confidentiality and security limitations. All electronic communications initiated by *Spring Occupational Therapy Inc.* will attempt to keep any protected health information of its clients confidential and will not share, sell, rent, or distribute in any way the contact information, including e-mail addresses, of its clients or affiliates. All clients and affiliates of *Spring Occupational Therapy Inc.* will automatically receive e-mail updates of information including such things as appointment reminders, changes of schedule or hours, and newsletters, unless otherwise indicated by such individuals/organizations in writing . No identifying information or Protected Health Information will be used by *Spring Occupational Therapy Inc.* for the purposes of any Social Media without client/guardian consent.

I accept all e-mail communication initiated by *Spring Occupational Therapy Inc.* and the guidelines accompanying use of e-mail communication as outlined above, including appointment reminders, program changes, and newsletters.
I accept responsibility for notifying *Spring Occupational Therapy Inc.* of any changes to my preferences.

____ _________________________
Parent or Guardian Signature Date