Parent/Guardian Information

Name: _____

Relationship to child: _____

Email: _____

Phone: _____

Child's Information

First Name: _____

Last Name: _____

Date of Birth: _____ /_____ /_____ (DD/MM/YYYY)

Age: _____

Gender identity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medical History

Primary Diagnosis (if applicable):

_____

Other Medical Conditions:

_____

Medications (if any):

_____

Allergies:

_____

Were there any complications, illnesses or stress during pregnancy and/or labour?

_____

_____

Gestation at child's birth?

_____

Past medical history (hospitalisations, surgeries, chronic illness):

_____

_____

Child's Profile

Child's Interests and Hobbies (this will help us establish rapport):

_____

Child's Personality (shy, outgoing, etc.):

_____

Living Situation (with parents, foster care, etc.):

_____

Siblings (names and ages):

_____

School/Daycare Information:

- Name of School/Daycare: _____
- Grade/Class: _____
- Teacher's Name: _____

Daily Routine (morning, afternoon, evening activities):

_____

_____

Support System (family, friends, community services):

_____

_____

Therapy Services Required

O Initial Occupational Therapy Consultation

O Ongoing Support and Therapy

Does your child receive any other therapy services?

O Physiotherapy

O Speech Therapy

O Other (please specify): _____

Functional Assessment

Please select any where your child experiences delays or difficulties:

- O Self-Care Skills (dressing, bathing, grooming, toileting)
- O Mobility (crawling, walking, running, use of assistive devices)
- O Fine Motor Skills (grasping, writing, cutting)
- O Gross Motor Skills (jumping, climbing, balance)
- O Sensory Preferences (sensitivities to sound, light, textures)
- O Play Skills (types of play, interaction with peers)
- O Communication Skills (verbal, non-verbal, assistive technology use)
- O Behavioural and Emotional Regulation (tantrums, coping mechanisms)
- O Cognitive Function (attention, memory, problem-solving)
- O Feeding Issues (difficulty swallowing, gagging, choking, food aversions)
- O Mealtime Behaviours (refusing to eat, prolonged mealtimes, spitting out food)

Detailed Concerns and Therapy Needs

Please explain any concerns you have and how we might best support your child:

_____

_____

_____

_____

Please list your short term goals for your child:

_____

_____

_____

Please list your long term goals for your child:

_____

_____

_____

Funding Information (required)

- O NDIS
- O Private Health Insurance
- O Self-funded
- O Other (Please specify): _____

How did you hear about us?

_____

Consent for Communication

- O I agree to sign up for news and updates
- O I do not agree to sign up for news and updates

Consent for Treatment and Data Use

I, _____ (Parent/Guardian Name), acknowledge that the information provided is accurate to the best of my knowledge.

I consent to the occupational therapy assessment and treatment for _____ (Child's Name) as recommended by the therapists.

I understand that this information may be used to facilitate care and services tailored to my child's needs. I acknowledge that I have read and understand and agree to be bound by the privacy policy.

Signature: _____ Date: _____

Once you complete this form please return it to hello@bloom-ps.com.au and **please include** any NDIS plans, relevant reports, evaluations, assessments or additional information that may assist us in providing appropriate services. Thank you!