**展翅飞翔： 家庭协助项目SOAR Family Support Services [initial consult]**

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| **Child’s name:**  **Nickname:** | | **DOB:**  **Child’s age at first visit:** | | **Referred by:**  **Date of first visit:** | |
| **Location:**  **Specialists Present:** | | | | | |
| **Parents:** | **Mother:** | | **Father:** | | |
| **Notes:** | | **Notes:** | | |
| **Other significant family members/family dynamics:** | | | | | |
| **Diagnosis/reason for referral:** | | | | | |
| **Birth and Medical History:**  Ceaser? Premmie?  Scans? Reports? Hospital visits? | | | | | |
| **Current concerns:** | | | | | |
| **Developmental history and current ability:**  **Feeding: milk/solids/self feeding/finger foods/texture preferences (age and ability)** | | | | | |
| **Notes**  **Developmental and behavioural:**  **OT**  **Sensory issues:**  **Speech:**  **Physical:**  **Head control/Rolling/Sitting/Standing/walking**  **Grosse motor:**  **Fine motor:**  **Weakness?** | | | | | **Recommendations:** |