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Participant Application and Health History
Occupational Therapy

General Information

Client Name:			D.O.B.:
Age:	Height:	Weight:	Gender:
Address:			
Phone:		Email:	
Alternate phone:		Emergency Contact:	
Person Completing form:			
Parent / Guardian:			
Address if different from above:			
Referring Physician:			

Health History

Please add additional pages as needed

Diagnosis & Date of Onset:	
Birth History:	
Medical / Developmental History / Developmental Milestones:	
Previous Intervention:	
Current Intervention / Location:	

Medications (name, dose, frequency):	
Insurance Provider:	

Please list any past or current challenges in the following areas:

Area	Concerns	No Concerns	Comments
Vision			
Hearing			
Touch / Sensation			
Movement			
Sensory Processing			
Communication			
Cognition			
Attention			
Cardiovascular / Heart			
Respiratory / Breathing			
Digestion			
Elimination			
Mental Health / Emotional			
Behavioral			
Pain			
Bones / Joints			
Muscular			
Allergies			

Function

Primary Goal Areas / Reason for Seeking Services:

Physical Function and Mobility (please list concerns)

Area	Concerns	No Concerns	Comments
Walking			
Transfers out of bed			
Transfers out of chair			
Transfer in / out of car			
Transfers in tub / shower			
Transporting items			
Able to maintain balance for dressing			
Running, jumping			
Bike riding			
Other:			

Psychological and Social Function and History (please list areas of concern)

Area	Concerns	No Concerns	Comments
Mental health diagnosis			
Support systems			
Family structure			
School or work			
Relationships with others / friendships			
Ability to care for others (people / animals)			
Play / leisure			
Other:			

Daily Activities and Occupational History

Dressing

Status	Shirt	Pants	Jacket	Socks	Shoes
Independent					
Assistance Required					
Describe:					

Undressing

Status	Shirt	Pants	Jacket	Socks	Shoes
Independent					
Assistance Required					
Describe:					

Fasteners

Status	Buttons	Zippers	Velcro	Tying	Snaps
Independent					
Assistance Required					
Describe:					

Feeding

Eats solids: Y N **Tube Fed:** Y N **Thickened liquids:** Y N **Bottle Fed:** Y N

Status	Fork	Spoon	Knife	Fingers	Cup
Independent					
Assistance Required					
Describe:					

Eating (please check all that apply)

Area	**Yes**	**No**	**Comments**
Eats age appropriate foods			
Eats variety of textures (puree, crunchy, chewy, soft)			
Eats variety of colors			
Eats all food groups			
Picky eater			
Messy eater			

Area	Yes	No	Comments
Requires specific food presentation			
Gags or vomits			
Describe:			

Grooming / Hygiene

Status	Bathing / showering	Brushing / styling hair	Brushing teeth	Washing hands	Nasal care / blows nose
Independent					
Assistance Required					
Describe:					

Toileting (please check)

Age appropriate	Assistance required	Requires medication	Area of concern
Describe:			

Regulation / Sleep

Area	Yes	No	Comments
Falls asleep Independently			
Naps			
Wakes during night			
How many hours of sleep per day?			
Describe:			

Play / Leisure

How many hours of screen time per day (average)?
How much exercise / outdoor time / day (average)?
Please list preferred free time activities. Describe any adaptations or concerns.

School / Work
Educational level completed:

Please describe school or work. Describe any adaptations or concerns.

PHOTO RELEASE

I DO ☐ or **I DO NOT ☐**

Consent to and authorize the use and reproduction of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibits, possible use on website, or for any other use for benefit of Making Strides LLC.

Signature: _____ Date:_____
Client, Parent or Legal Guardian

EMERGENCY TREATMENT RELEASE

Physician:		Phone:
Physician Address:		
Preferred Medical Facility:		
Health Insurance:		
Insurance Policy Number:		

Emergency Contact Information:

Name	Relationship	Phone

☐ **I GIVE MY CONSENT**, in the event of a medical emergency, for Making Strides LLC to provide such medical assistance as deemed to be necessary. I authorize any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the above-named volunteer, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.
☐ **I DO NOT GIVE MY CONSENT** for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of / used by the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Signature: _____ Date: _____
Client, Parent or Legal Guardian