TicTalkToes
SPEECH AND OCCUPATIONAL THERAPY

New Patient Registration

Child's Name: _____ DOB: ____/____/____ ☐ Male ☐ Female

Address: _____City/State: _____ Zip: _____

Parent(s) /Guardian(s) Name(s): _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Emergency Contact Name: _____ Relationship to Child: _____

Emergency Contact Phone #1:_____ Phone #2:_____

What is the best way to contact you for scheduling? ___ Email ___ Phone

If you have a balance due, how would you like to be billed? ___ Email (preferred) ___ Mail

Referred By: _____

How did you hear about TicTalkToes Therapy? _____

Family Background

What is the child's primary language? _____

What language(s) does the child speak? _____

_

Language(s) spoken in the home: _____

Other children in the family (names & ages):

_____

Do any other family members have any developmental delays? ☐ Yes ☐ No

If yes, please state the family member's relationship to the child and describe the difficulties:

_____

_____

Prenatal and Birth History

This child is your: ☐ Biological child ☐ Adopted child ☐ Foster Child

Mother's age at child's birth: _____ Did mother receive routine prenatal care? ☐ Yes ☐ No

Length of pregnancy: _____ Birth weight: _____lbs _____oz Apgar Score _____

Type of Delivery: ☐ Cesarean ☐ Vaginal ☐ Breech ☐ Feet First

Any unusual conditions that may have affected the pregnancy or birth?

_____

_____

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Medical History

Physician's Name: _____ Phone:_____

Physician's Address: _____

Other Physicians/Specialists Involved In Care:

_____

If the child is taking vitamins or medication(s), please list them:

_____

Please list any allergies and how the reactions are managed:

_____

Has the child had any surgeries? If yes, please list the type and when it was completed:

_____

Please indicate if the child has been diagnosed with:

☐ Autism	☐ Down Syndrome	☐ Auditory Processing Disorder	☐ Developmental Delay
☐ Hearing Loss	☐ Cerebral Palsy	☐ Intellectual Disability	☐ Congenital Anomaly
☐ Genetic Disorder	☐ Dyspraxia	☐ Sensory Disorder	☐ Other

Does the child have any difficulty with the following?

☐ Attention	☐ Aggression	☐ Anger	☐ Frustration Tolerance
☐ Chewing or eating	☐ Excessive drooling	☐ Answering simple questions	☐ Answering –wh questions
☐ Understanding people	☐ Following directions	☐ Producing speech sounds	☐ Stuttering
☐ Reading	☐ School work	☐ Maintaining eye contact	☐ Transitions
☐ Remembering	☐ Word Retrieval	☐ Telling or retelling a story	☐ Talking in specific settings

Other difficulties not listed above:

_____

Please describe any of the above:

_____

_____

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Educational History

School: _____ Grade:_____

Teacher(s): _____

Has an IEP or IFSP been developed for the child? If yes, please include the date of the last written

IFSP/IEP: _____

Does your child receive special services? If yes, please describe:

_____

_____

School-based or Private Therapy? ☐ OT ☐ PT ☐ Speech & Language ☐ Behavioral Therapist ☐ Psychologist ☐ None ☐ Other: _____

Hand Dominance? ☐ Right ☐ Left ☐ Both

Developmental History

At what approximate age did the child do the following?:

Sit up:	Crawl:	Stand up:
Walk:	Babble:	First word(s):
Feed self:	Use utensils:	Dress self:
Drink from an open cup:	Use the toilet:	Ride a tricycle:

Language

What percentage of the child's speech do you understand? _____%
How well do people outside of the family understand their speech? _____%
How many words does the child say:_____
Please indicate the length of words the child uses in a sentence:
☐ 2 words ☐ 3 words ☐ 4 words ☐ 5+ words
If the child is not using words, how do they primarily communicate?

_____

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Please check ***only*** those items that are ***persistent*** and interfere with the child's performance.

Fine Motor/Visual Motor/Visual Perceptual

- ❑ Appears not to have a preferred hand
- ❑ Has trouble turning objects to fit(puzzles, putting items away, etc)
- ❑ Has problem sorting or matching
- ❑ Has trouble copying designs (building blocks, copying from board, writing letters)
- ❑ Has an unusual grip on pencils, etc
- ❑ Makes letters, numbers, shapes that are not recognizable
- ❑ Has trouble with excessive size when writing
- ❑ Cannot space letters and words correctly
- ❑ Writes letters, numbers backward
- ❑ Cannot trace over lines
- ❑ Exhibits hand tremor when writing
- ❑ Changes hands for fine motor task
- ❑ Difficulty using both sides of body together (opening containers, using scissors, skipping, clapping to a rhythm, etc)
- ❑ Frequently drops objects or grasps objects too tight
- ❑ Exhibits difficulty snipping paper with scissors

Comments_____
_____
_____

Postural Control & Stability

- ❑ Appears to fatigue easily and poor endurance
- ❑ Appears with weak or with low muscle tone
- ❑ Exhibits difficulty sitting upright on floor
- ❑ Often sits in a W-sit position on the floor
- ❑ Cannot keep up with peers on playground
- ❑ Demonstrates poor ball skills (rolling, kicking, catching or throwing)
- ❑ Demonstrates poor sense of rhythm or appears clumsy
- ❑ Stumbles & falls more frequently than other same-aged children.
- ❑ Exhibits difficulty accessing preschool age playground equipment
- ❑ Exhibits difficulty maintaining balance for challenging activities.

Self-Care Skills

- ❑ Difficulty with feeding self with utensils
- ❑ Requires assistance with toileting
- ❑ Difficult with undressing/dressing self
- ❑ Exhibits difficulty with manipulation of fasteners (buttons, zippers)

Comments_____
_____

Social / Sensory Concerns

- ❑ Poor eye contact
- ❑ Invades space of others
- ❑ Seldom interacts/plays with peers
- ❑ Becomes angry for no apparent reason
- ❑ Has difficulty expressing wants/needs
- ❑ Dislikes trying new or unfamiliar activity
- ❑ Becomes upset with change in routine
- ❑ Has specific toy/equipment preferences and refuses substitutes
- ❑ Engages in excessive activity which seems purposeless, restless, undirected
- ❑ Exhibits aggressive behaviors with peers
- ❑ Handles toys/objects inappropriately
- ❑ Does not know how to use free time
- ❑ Poor impulse control
- ❑ Low frustration tolerance
- ❑ Overly sensitive to any of following- Circle one (Noise, Lighting, Touch, Movement, Smells, Foods)
  List:_____
- ❑ Seeks deep pressure (hugs, leaning into people or objects)
- ❑ Avoids elevated surfaces (playground equipment, steps, climbing)
- ❑ Exhibits unusual response to pain (over reacts or doesn't acknowledge)
- ❑ Overactive (excessive movement)
- ❑ Has self-stimulatory or self-abusive behaviors
- ❑ Cannot stand in middle of line
- ❑ Excessively seeks materials that provide a sensation-Circle (tactile, auditory, oral, movement, etc)
- ❑ Easily distracted by noise or visual stimuli
- ❑ Frequently out of chair
- ❑ Kneels/tips back/falls out of chair
- ❑ Frequently lays head on desk or props head in hands
- ❑ Bumps into furniture or walls while walking
- ❑ Circle one: Likes/dislikes swinging
- ❑ Will not hold onto tools (crayons, pencils, utensils, scissors
- ❑ Looks peripherally at objects
- ❑ Avoids touching materials such as glue & paint
- ❑ Is a picky eater

Comments_____
_____
_____

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Evaluation

Briefly describe why you're seeking an evaluation by an occupational therapist at this time:

_____

_____

What are you expecting out of this evaluation / meeting?

_____

_____

Has the child had a previous occupational therapy evaluation / treatment? ☐ Yes ☐ No

By whom: _____ When: _____

Describe the results:

_____

_____

What are your primary concerns/goals for therapy regarding your child?

_____

What are you child's strengths?

_____

Please provide any other additional information that might be helpful in the evaluation (e.g. their likes or dislikes, their behavior, strategies you might use to help them…etc) and any goals that you would like your child to focus on:

_____

_____

_____

Person completing form: _____

Relationship to Child _____ Date: _____

THANK YOU FOR COMPLETING THIS FORM!

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