Occupational Profile

TOTAL REHAB CENTER

Please complete all sections relevant to your visit.

PERTINENT INFORMATION:

Home situation – Are parents married/divorced? Any siblings? Response:
When did parents become concerned? Response:

PLEASE DESCRIBE THE MAJOR CONCERNS YOU HAVE AS TO WHY YOU ARE SEEKING OCCUPATIONAL THERAPY FOR YOUR CHILD:

What are the overall goals for your child receiving Occupational Therapy? Response:
What are you most concerned about now? Response:

IN ORDER TO MEET YOUR NEEDS AND THE NEEDS OF YOUR CHILD IT IS HELPFUL FOR ME TO BE AWARE OF ALL OTHER SERVICES YOUR CHILD IS RECEIVING AT THIS TIME -

Have you or are you receiving Occupational Therapy services previously? If so, where, from whom and how long? Response:

Have you or are you receiving speech and language services? If so, where, from whom and how long?

Response:

Have you or are you receiving psychology or social work services to support you and your child? If so, where, from whom and how long?

Response:

Please list all other services being received either at school or privately and include the names of the providers:

Response:

Please describe any significant prenatal and birth history.

Response:

Please describe any significant early developmental history.

Response:

Please describe any significant family history.

Response:

FUNCTIONAL SKILLS:

Gross Motor:

Describe your child's gross motor skills (Can he/she roll, crawl, walk, climb on furniture?). Response:

Fine Motor/Tool Use (utensils, pencils):

Does your child pick up and manipulates small objects. Response:
Does your child hold a bottle, a sippy cup, hold a spoon or fork or utensil you use during daily activities. Response:
How does your child grasp blocks, stuffed animals, or favorite small toys? Response:

Dressing Skills:

Does your child assist with dressing? Response:
If your child assists with dressing describe how. (e.g. Lifts arms for shirt, or sock, lifts legs during diaper changing) Response:

Play Skills:

Describe the play activities that your child engages in. Response:
How does your child play around his peers? Response:
Does your child play by him/herself? For how long? Response:

If your child plays by him/herself & has a problem making a toy work, or getting a toy, how does he/she get your attention?
Response:

Daycare/Childcare

Are you the primary caregiver for your child?

Response:

Who else looks after your child on a regular basis?

Response:

Does your child attend daycare/childcare? If so where and for how long during the week?

Response:

If in daycare/childcare does your child transition into and out with ease?

Response:

RESPONSE TO SENSORY STIMULI:

General State:

How does your child sooth him/herself?
Response:

Touch Response:

Is your child comfortable with the feel of clothes such as the texture of fabrics, jeans, socks and shoes?
Response:

Is your child comfortable with hair brushing, washing, cutting, nail cutting, teeth brushing, etc.?
Response:

Does your child engage with you and in an age expected way assist with in hair brushing, washing, teeth brushing, etc.? Response:

Movement and Balance:

Is your child comfortable being moved off balance? For example, in roughhouse play being tipped or rocked. Response:
Does your child enjoy movement activities? Response:
Does your child engage in movement activities to a greater degree than his peers? For example, does he /she frequently engage in rolling back and forth, rocking on all fours or rocking when standing. Response:

Touch and Motor Awareness:

When you assist your child with a physical task such as dressing or getting into the car, does your child assist with the movement? Response:
If your child is mobile does he/she negotiate moving around the room, around furniture, around objects and other people successfully? Response:

Awareness of Sound:

Does your child enjoy sounds that occur in the environment? Response:
Does your child enjoy making sounds? For example, makes loud sounds, sings to himself, hums. Response:
Is your child comfortable with everyday household sounds, such as the sound of the refrigerator, the washing machine, the flushing of the toilet? Response:

Visual Awareness:

Is your child comfortable in a busy visual environment? For example a busy playroom or the mall. Response:
Is your child comfortable in sunlight? Response:
Does your child make eye contact with others? Response:

Awareness of Taste and Smell:

What are your child's eating habits? Response:
Is your child's diet limited due to texture? Response:
Does your child exhibit any sensitivity to smells? Response:
Is your child sensitive or allergic to any foods? Response:

Internal Sensations:

How does your child communicate or what are the behaviors you recognize that indicate that your child is hungry, thirsty, tired? Response:

Need for Routine:

Does your child do better with a structured routine? Response:

What happens if the routine is altered? Response:

Attention Span:

Describe your child's attention span. Response:
What does your child enjoy doing for long periods? Response:

Transitions:

Does your child adapt well and with ease during transitions? For example, leaving the park, getting into the car to go to the store, packing away toys for dinner. Response:

Activity level:

Do you consider your child's activity level average compared to his peers? If no, please describe. Response:

Peers:

Does your child enjoy social interaction and communicating with other children? Response:
Does he/she maintain social interactions with other infants and children in a way that you expect for his/her age? Response:

Parent Signature:_____

Date: _____