RESILIENCE
OCCUPATIONAL THERAPY

Please kindly fill out the following information:

a. Client information and health
b. Medical History
c. Areas of concern

Clients full name: Today's date:

Date of birth/chronological age: Gender: M F

Place of birth:

Full home address:

Home phone number:

Mother's name: Father's name:

Mother's mobile number: Father's mobile number:

Mother's email address: Father's email address:

Mother's employer: Father's employer:

Mother's position: Father's position:

Primary contact person: Mother Father

Other:

(please provide with name, phone number and email):

Names and ages of siblings :

1

2

3

4

5

Language spoken at home: Name of school and grade level:

Childs dominant language: Language(s) spoken at school:

What are your main concerns with your child?

Who has referred the child for a therapy evaluation?

Was the child born at : Full term Premature

Delivery: Vaginal Caesarean section

Were there any problems during pregnancy or delivery?

If yes please provide with detail:

How was the child's health during the early stages of life?

Please provide with details:

Does your child have a specific diagnosis related to your concern?

If yes please provide detail:

Does he or she have any other medical issues?

If yes please give details:

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Does he or she have any other medical issues?

If yes please give details:

Please give details of any medication your child is taking:

Does your child have any allergies?

If yes please provide detail:

Details of hearing test date

Result: ☐ Normal ☐ Abnormal ☐ Unknown

Details:

Details of latest vision test date

Result ☐ Normal ☐ Abnormal ☐ Unknown Wears glasses ☐ Yes ☐ No

Details:

What are your child's interest/ hobbies?

What are your child's strengths?

Has your child ever received any form of therapy intervention in the past, if yes, please elaborate:

C. Areas of concern

Speech: ☐ Yes ☐ No

If yes, please provide details:

Fine motor: ☐ Yes ☐ No

(i.e. tying shoe laces, drawing), if yes, please provide detail:

Gross motor: ☐ Yes ☐ No

(i.e. jumping, standing, walking), if yes, please provide with detail:

Behavioural: ☐ Yes: ☐ No

Social interaction: ☐ Yes: ☐ No

Learning difficulties: ☐ Yes: ☐ No:

Attention/ concentration: ☐ Yes: ☐ No:

Mental health: ☐ Yes: ☐ No:

If yes, to any of the above, please elaborate in the given space below:

Please indicate any other area of concern/s that have not been included:

At present, what is your child's level of ability? Please provide with detail:

What days and times would you like your child to be seen for treatment

Where did you hear about us

Which method of payment do you prefer ☐ Cash ☐ medical aid

Please provide us with your medical aid particulars below:

Would you like us to contact you for any upcoming events, if yes please provide us with your email address, so that we are able to add you to our mailing list

Lastly, on the proposed consultation date, please provide us with the following documents:

1) The child's latest school report, if he/she is at school (2) The child's birth certificate (3) Guardian/ parents identity documents (4)Medical records (doctor's reports, prescription etc)