KID O'THERAPY, LLC
Play With Purpose
Physical Therapy, Speech Therapy, &
Occupational Therapy for Children

41 Main Street
Topsham, ME 04086
Phone: (207) 844-8287
Fax: (207) 844-8245

www.kidotherapy.com

Child's Name: _____ Date of Birth: _____

Age: ____ Sex: _____ Preferred Gender Pronouns: she/her he/him they/them

Parent/Guardian 1: _____ Parent/Guardian Date of Birth: _____

Home Address: _____

Mailing Address: _____

Place of Employment: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email Address: _____

Parent/Guardian SSN: _____

Parent/Guardian Driver's license #: _____

Parent/Guardian 2: _____ Parent/Guardian 2 Date of Birth: _____

Home Address: _____

Mailing Address: _____

Place of Employment: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email Address: _____

Parent/Guardian 2 SSN: _____

Parent/Guardian 2 Driver's license #: _____

Insurance Provider: _____ Subscriber Name: _____

Policy # _____ Group#: _____

Rev: 12/20/2021

Subscriber DOB:_____ Relationship to Child: _____

Please state current custody arrangements (i.e. sole, joint, foster):

Who is the primary Contact Person _____Make sure information is listed above.

Child's School: _____

Hours/Days Attended: _____

Family/Persons living in the home:

Name	Relationship to child

Family History:

Allergies		Grandparent		Mother/Father		Sibling
Learning Disability		Grandparent		Mother/Father		Sibling
Sleep Disorder		Grandparent		Mother/Father		Sibling
Substance Abuse		Grandparent		Mother/Father		Sibling
Vision Deficits		Grandparent		Mother/Father		Sibling
Hearing Loss		Grandparent		Mother/Father		Sibling
Arthritis		Grandparent		Mother/Father		Sibling
Sexual Abuse		Grandparent		Mother/Father		Sibling
Intellectual Disabilities		Grandparent		Mother/Father		Sibling
Diabetes		Grandparent		Mother/Father		Sibling
Cancer		Grandparent		Mother/Father		Sibling
Psychiatric Disorders		Grandparent		Mother/Father		Sibling

CHILD'S MEDICAL HISTORY:

Primary Care Physician: _____Physician Phone: _____

Physician's address: _____

Other Specialists/Physicians/Therapists:

Name	Area of Specialty	Duration/Frequency

Has your child had any of the following exams/evaluations/assessments?

	Date of Most Recent:	Results:
Hearing		
Vision		
Occupational Therapy		
Physical Therapy		
Speech and Language		
Developmental		
Neurological		
Physiological		
Imaging (ie X-Ray, MRI, CT scan)		

Current Medical Diagnoses:

	Anxiety		Apraxia		Spina Bifida
	Asthma		Attention Deficit Disorder		Attention Deficit Disorder with Hyperactivity
	Autism Spectrum Disorder		Traumatic Brain Injury		Cerebral Palsy
	Hearing Impairment		Depression		Diabetes
	Down Syndrome		Fine Motor Delays		Gross Motor Delays
	Visual Impairment		Juvenile Rheumatoid Arthritis		Intellectual Disabilities
	Pervasive Developmental Disorder-NOS		Post-Traumatic Stress Disorder		Seizures
	Sensory Integration Dysfunction		Obsessive Compulsive Disorder		Brain Tumor

Other (Please List):

_____

_____

Allergies/Dietary Needs:

_____

_____

Current Medications/Supplements:

Medication/Supplement	Dosage

Previous Hospitalizations/Surgical Procedures:

Reason	Date(s)

DEVELOPMENTAL HISTORY:

Complications or problems during pregnancy or at birth:

_____

_____

Length of pregnancy: _____ Birth Weight: _____

Medications/drugs used during pregnancy:

_____

Alcohol consumption during pregnancy: Yes No

BEHAVIORAL HISTORY:

My child...	Often	Sometimes	Never
Follows age-appropriate verbal directions			
Appears to be restless or fidgety			
Can be impulsive			
Gets upset easily			
Tires easily			
May pinch, bite, or hurt oneself or others			
Has a difficult time with change/transitions			
Is easily distracted			
Understands personal safety			
Lines up objects in a row			
Repeats movements over and over			
Angers easily			
Is fearful on new situations/people			

FAMILY CONCERNS:

What are your concerns about your child?

_____

_____

_____

_____

What changes would you like to see in your child's development, behavior, fine motor and gross motor skills?

_____

_____

_____

_____