SAMUEL MERRITT UNIVERSITY

Occupational Therapy Pediatric Community Participant Lab Client Information Form

Client Information

Child First Name

Child Last Name

Parent(s) Full Name(s)

Child Birthdate

Age

Address

City

State

ZIP Code

Gender

Female

Male

Non-binary

Parent Mobile Phone

Home Phone

Parent E-mail

Caregiver or Emergency Contact

Name

Relationship

Phone

E-mail

Physician's Information

Pediatrician's Name

Office Phone

Office Fax

E-mail (if available)

How did you hear about our lab?

Medical & Developmental Information

Child's diagnosis (if any)

When did your child receive this diagnosis?

Prematurity Yes No

Reflux Yes No

Shunt Yes No

Seizures Yes No

Diabetes Yes No

Asthma/ Hayfever Yes No

Cervical spine instability Yes No

Gastrostomy tube Yes No

Sleep problems Yes No

Eating problems Yes No

Bladder problems	Yes No	Bowel problems	Yes No
Diarrhea / constipation	Yes No	Vision problems	Yes No
Hearing problems	Yes No	Balance problems	Yes No
Delayed developmental milestones	Yes No	Surgeries	Yes No

Please explain any item checked YES above:

Allergies

Please indicate any significant medical history not covered above.

Please list any medications your child takes and the reason for the medication:

Is your child currently receiving any other therapies or special services? Please describe.

Has your child previously received any therapies, special services, or testing in the past? Please describe.

Cautions: Tell us if there is anything we **shouldn't** do with your child or that we need to know for your child's **safety**

Information about your child

What are your child's favorite play activities? Areas of strength?

Does your child have trouble with age-appropriate **mobility** (standing, transferring, walking)? Please describe.

Do your child have trouble with age-appropriate **personal care** skills (dressing, bathing, brushing teeth/hair, feeding self, etc.)? Please describe.

Does your child have trouble with participation at school? Please describe.

Do your child have trouble with age-appropriate **home activities** (chores, family routines, etc.)? Please describe.

How about **accessing the community, playing with peers/siblings, or having fun?** Please describe your child's abilities/challenges in these areas.

How can we help you & your child?

Please tell us what your family would like to gain from working with occupational therapy. What would you like your child to be able to do or have change as a result of this 9 week session?

Does your family have any special cultural or spiritual practices that you would like us to follow while you are here? Please describe.

Does your child use any adaptive equipment?

Check all that apply

- Cane
- Walker
- Manual Wheelchair
- Power Wheelchair
- Other
- Shower chair/bench
- Splint/brace for hand/arm
- Splint/brace for foot/leg

Time Preference

Monday Afternoons October-December

Which time blocks are you available?

- 2:30pm-3:20pm
- 3:30pm-4:20pm

Notes

Unless otherwise stated, your participation in the community participant lab is based on your self referral. Please contact your doctor if you have any questions about your child's ability to participate in occupational therapy.

By typing or signing your name below you acknowledge the above and give the occupational therapy program at Samuel Merritt University permission to contact your physician to exchange your medical information, if needed:

Signature

Submitting the Form

Email: OTLab@samuelmerritt.edu

You may e-mail the completed form; however, e-mail may not be secure. Your form contains private health information that is protected by HIPPA. E-mail is not considered a HIPPA compliant method of communication unless it is encrypted. You may have an e-mail provider that offers you the opportunity to encrypt your message if you wish.

Fax: 510-457-4008

or Mail: OT CPL
450 30th Street, 4th floor
Oakland, CA 94609

Questions? Contact us:

OTLab@samuelmerritt.edu 510-879-9200 x 7456