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| --- | --- | --- | --- |
| Client: Age: | | | |
| Daily Routines | Family Routines/ Traditions | Important Settings | Interests |
| What does a typical day look like? | What does a typical day look like? What are some activities that are important to your family? Who are people your child interacts with often? (Yearly trips, family traditions, etc.) | Where does your family enjoy going? What activities do you want your child to have access to? Are their places you attend regularly? (This could include playing at the park, religious activities, Grandma’s house, etc.) | What does your child enjoy doing? What activities, characters and people that seem to engage your child? |
| Communication Goals | Medical Diagnosis | Hearing Information | Mobility/Movement |
| What are you confident that you understand your child is communicating? (Requesting, questioning, stating needs and emotions, etc.) | This is meant to highlight important medical notes and should link to an in-depth case history, | (Type and Degree of hearing loss, amplification and hearing age.) | Describe your child’s movement abilities. What do they enjoy doing and what can they do easily? |
| Prioritized Functions | PT/OT Needs | Cognition | Vision |
| Considering areas that need support, what is the most important to you and your family? | What can your child do with support? What areas would you like your child to have more independence in? | How easily does your child learn a new skill? How does your child maintain skills? | Does your child wear glasses or have any concerns with vision? |
| Specialist Notes: | Specialist Notes: | Specialist Notes: | Specialist Notes: |
|  |  |  |  |

Functional Priority:

Goal: Ex- Be able to eat snack independently with their siblings.

Goal: Ex- Be able to communicate choices during play time with their cousins.

Goal: Ex- Play with/ safely next to a friend at the park.