Leaps and Bounds
Pediatric Occupational Therapy

Background Information

Sleep Patterns

Does your child:

1. Have regular sleep patterns? _____ If no, please describe: _____

   _____

2. Wake frequently during the night? _____ If yes, please describe: _____

   _____

3. Tend to be an early riser, up and on the go? _____

4. Have a difficult time falling asleep? _____

Play Skills

1. What are your child's favorite toys to play with? _____

   _____

2. Who does your child prefer to play with (i.e., older/younger children; large/small variety of children) ? _____

   _____

3. How often does your child have play dates with peers? _____

4. Does your child tend to play by him/herself or engage in cooperative play with peers?

   _____

5. What activities does your child least enjoy? _____

   _____

6. Are there any things which your child tends to fear or avoid? _____

   _____

Other Services

Please list any professionals your child works with currently or in the past (i.e., cardiologist, chiropractor, neurologist, speech pathologist, occupational therapist, physical therapist, ophthalmologist/optometrist, orthopedist, ENT, psychologist/psychiatrist)

Name(s)	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please provide a general daily/weekly schedule that your child currently follows (i.e., school, therapies, extracurricular activities)