my CHILD'S therapy

Occupational Therapy Intake

General Information:

Gender
☐ Male
☐ Female
☐ Other

Child's name: ______________________________ Child's date of birth: ________________

Home address: ____

Parent/Guardian 1: ______________________ _________________ ____________________
Name Phone # E-mail

1- Emergency contact?
☐ Yes
☐ No

Parent/Guardian 2: ______________________ _________________ ____________________
Name Phone # E-mail

2- Emergency contact?
☐ Yes
☐ No

Pediatrician: __________________________ _________________ _______________________
Name Phone # Name of Practice

Please answer the following to the best of your ability:

What are your primary concerns for your child at this time and when did they start?

Previous or current evaluations/services

☐ behavioral therapy ☐ vision therapy ☐ nutritionist ☐ psychotherapy ☐ lactation consultant

☐ physical therapy ☐ occupational therapy ☐ speech therapy ☐ other:____________________

Pregnancy/birth- Term _______ weeks NICU ☐ yes, for ________ days ☐ no

Complications during pregnancy (gestational diabetes, preeclampsia, etc.) ☐ yes ☐ no

Complications during birth ☐ yes ☐ no

☐ premature ☐ breathing difficulty ☐ incubation ☐ jaundice ☐ transfusion ☐ forceps

☐ feeding difficulty ☐ suction ☐ congenital defect ☐ emergency cesarean

☐ tube fed ☐ low APGAR ☐ other:____

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Occupational therapy can address the following, please select your concerns:

Activities of Daily Living: tasks focused on taking care of one's body

- upper body dressing
- lower body dressing
- toileting
- bathing/showering
- assistive/personal device care
- shoe tying
- buttons/zippers/snaps
- personal hygiene/grooming (brushing teeth/hair, nail trimming)
- feeding self and eating

Major Developmental Milestones

- Rolling over:
- Sitting up independently:
- Crawling:
- Walking:

Feeding/Eating:

- food aversion
- using utensils
- using a cup/sippy cup
- manipulating food/fluid in mouth

Emotional Regulation/Behavior:

- impulse control
- recognizing/learning emotions of self/others
- using words instead of physical actions
- transitioning between activities, environments and to/away from people

Sensory Regulation/Sensitivity: can fall into both categories

- sensory seeking (spinning, running, jumping, flipping; likes deep pressure)
- sensory avoiding (sensitive to clothing material, textures, sounds, lights, foods; likes light pressure)

Play/Social Skills: spontaneous or organized activity by self or with others

- play with toys in appropriate manner
- following game rules
- independent play

- parallel play
- imitative play
- cooperative play
- sharing
- turn taking

Fine Motor Skills:

- handwriting (letter formation, spacing, legibility)
- hand/finger strength
- scissor skills
- in-hand manipulation of objects
- hand/finger range of motion

Balance and Coordination:

- bilateral coordination (using 2 hands/sides of body at once)
- crossing midline
- consistently clumsy (ataxia)
- collapses when crawling
- slouches when sitting

Vision (not just acuity):

- lazy eye
- inattention
- visual perception (copying from board/paper)
- visual motor
- letter/number recognition (visual memory)
- post-surgical therapy

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Executive Functioning:

- task initiation
- following directions
- task completion
- working memory
- planning
- attention to task
- maintaining eye contact
- organization

Instrumental Activities of Daily Living: typically for older kiddos with high levels of independence

- care of others/pets
- community mobility/engagement
- financial management
- medication management
- meal preparation
- safety awareness

Please list any allergies/medical diagnoses your child has:

Please list any major medical procedures/surgeries and medical illnesses (chickenpox, croup):

Please name any medications your child has taken for longer than 30 days and why:

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Has your child had any of the following? Check all that apply

- frequent colds
- lung condition/respiratory disorder
- heart condition
- hormonal problem
- joint or bone problem
- visual disorder/problem
- seizures or convulsions
- failure to thrive
- diarrhea
- head injury/concussion
- frequent strep throat/sore throat
- frequent ear infections
- ear tubes
- anemia/blood disorder
- urinary problems/infections
- fractured bones
- eye infection
- stomach disorder
- feeding problems
- hearing loss/ear disorder
- ingestion of toxins/poisons/objects
- birth defect/genetic disorder
- allergies or asthma
- kidney/renal disorder
- muscle disorder/problem
- neurological disorder
- skin disorder/problem
- vomiting/digestion issues
- significant accidents/trauma
- constipation
- colic
- GERD/Reflux

Does your child participate in an education program (preschool or higher)? ☐ yes ☐ no

Name of current school: ____

Teacher: __________________________ ___________________ ______________________

Name Phone # E-mail

Does your child have an Individualized Education Plan (IEP) or an Individualized Family Service Plan (IFSP)? ☐ yes ☐ no

If yes, what services does he/she receive?

Has the teacher expressed any concerns? If yes, please describe. ☐ yes ☐ no

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If child does not attend an educational program, please provide their daily schedule and who their main caretaker is below:

Please list who the child lives with at home (parents, siblings, etc.)