Occupational Therapy Pediatric Intake Form

Child's Information				
Last Name			**First Name**	
Date of Birth	**Age**	**Gender**	**Ethnicity**	**Primary Language(s) Spoken**

Parent/Guardian Information Please put a * by your preferred method of contact (phone/email) If addresses differ, please put a * next to where the child spends most of their time			
Parent/Guardian 1		**Parent/Guardian 2**	
Last Name	**First Name**	**Last Name**	**First Name**
Relationship to Child		**Relationship to Child**	
Primary Phone		**Primary Phone**	
Email		**Email**	
Street Address		**Street Address**	
City, State, Zip Code		**City, State, Zip Code**	

Other People in the Household Please list anyone else who lives in the household and their relationship to the child	
Name (age)	**Relationship to the child**

Referred by:		**Main Concerns:**	
Physician:		**Facility:**	
Daycare/preschool/school (if applicable):			
Name of school:		**Grade:**	
Name of Teacher:		**Does your child receive additional services in school?**	**Yes** ☐ **No** ☐
Please describe your child's strengths in school:		**Is your child having difficulty with any school subjects? If so, please explain.**	
Evaluation/Treatment History:			
Has your child had any previous evaluations or tests? If yes, please explain.			

Has your child received any previous therapy outside of school (e.g., Speech Therapy, Occupational Therapy, etc.)? If yes, please explain.
Other Information:
What are your child's favorite interests/games/activities/toys?
Please tell us anything that may help us better understand your child:

Medical/Developmental History

Birth/Health History			
Please explain any difficulties before, during, or after the birth of your child:			
Length of pregnancy:		**Birth weight:**	
Length of stay in the hospital:		**Type of delivery:**	
Please explain any current medical conditions and/or diagnoses (e.g., ADHD, autism):			
Please list any medication your child takes regularly:			

Hearing	No	Yes	If yes, explain:
Have you ever had concerns about your child's hearing?	☐	☐	
Does your child use any amplification or other devices to aid hearing?	☐	☐	
Did/does your child have frequent ear infections?	☐	☐	
When was your child's most recent hearing screening?			

Vision	No	Yes	If yes, explain:
Have you ever had concerns about your child's vision?			
Does your child currently wear corrective lenses?			

Speech and Language Development	
At approximately what age did your child begin to do the following: (Write N/A if not applicable)	**Age:**
Babble (sound combinations such as "bababa" or "gaga")	
Say first word	
Jabber in nonsense sentences that sound like adult language	
Begin to put words together (e.g., "mommy play", "want drink")	
Use complete sentences	

Is there any family history (including siblings) of speech, language, or learning difficulties? If yes, please describe.

Other Developmental Areas Please indicate if you have had in the past or currently have concerns in the following areas of development:	**Current Concern**	**Past Concern**
Motor development (e.g., crawling, sitting, walking, running)		
Self-help (e.g., dressing, toileting)		
Feeding (e.g., drooling, choking, sensitivity to textures)		
Early play (e.g., using toys appropriately)		
Please explain any concerns indicated:		

Occupational Therapy information

Behavior and Social Skills					
	Yes	No		Yes	No
Does your child initiate conversation?	☐	☐	Does your child take turns with peers?	☐	☐
Does your child make eye contact?	☐	☐	Does your child display aggression?	☐	☐
Does your child have safety awareness?	☐	☐	Does your child prefer to play alone?	☐	☐

Is your child Impulsive/takes risks?	☐	☐	Does your child have tantrums (etc., scream, throw items, or hit).	☐	☐
Does your child pay attention?	☐	☐	Is your child extremely sensitive to sounds, textures, or touch?	☐	☐
Does your child listen well?	☐	☐	Is your child unable to self-calm?	☐	☐
Does your child play well with others?	☐	☐	Does your child like crowds?	☐	☐
Is your child able to follow verbal directions?	☐	☐	Does your child do well with change?	☐	☐
Please explain any "yes" answers about your concerns. Please give examples if possible.					

Daily Routine-Self Care		
	Yes	No
Does your child have difficulty with the morning/night time routine?	☐	☐
Does your child have difficulty falling asleep?	☐	☐
Does your child wake during the night?	☐	☐
Is your child able to fasten clothing (e.g., buttons, zippers, snaps)	☐	☐
Can your child dress her/himself (e.g., pull up pants/underwear, put on shirt/socks/shoes)	☐	☐
Is your child bathroom trained	☐	☐

Is your child able to brush teeth and hair independently	☐	☐

Please explain any "yes" answers about your concerns. Please give examples if possible.

Sensory Processing		
	Yes	No
Does your child tolerate self-care (e.g., bathing, tooth brushing, hair brushing)?	☐	☐
Does your child appear clumsy (e.g., trips, bumps into objects/people, trouble with coordinating body parts)?	☐	☐
Does your child have a fear of using playground equipment (e.g., swinging, feet leaving the ground, heights)?	☐	☐
Is your child constantly moving, seeks intense pressure/movement?	☐	☐
Does your child have difficulty keeping hands to him/herself?	☐	☐
Does your child avoid messy play/doesn't like when hands get dirty?	☐	☐
Does your child appear overly sensitive to certain textures, smells, noises?	☐	☐
Does your child chew on non-edible objects/puts them in his/her mouth?	☐	☐
Does your child often invade others' personal space?	☐	☐
Does your child have poor body awareness (e.g., unaware if hands are dirty, being touched or bumped into)?	☐	☐

Please explain any "yes" answers about your concerns. Please give examples if possible.