kids therapy made simple

Occupational Therapy Intake

General Information

today's date: _____

child's name: _____

date of birth: _____

address: _____

gender: ☐ male ☐ female

_____

parent name: _____

email: _____

occupation: _____

phone (h): _____ phone (c): _____

parent name: _____

email: _____

occupation: _____

phone (h): _____ phone (c): _____

names and ages of those living in the home: _____

primary language spoken at home: _____

_____

pediatrician: _____

referred by: _____

pediatrician phone number: _____

Reason for Today's Evaluation

What are your primary concerns with your child at this time?

When did you first notice these concerns and how did they become apparent to you?

Please describe the reasons for seeking occupational therapy services at this time.

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Has your child received **previous** evaluations or interventions? ☐ yes ☐ no

If yes, what kind, where and when?

Is your child **currently** receiving other interventions or therapies? ☐ yes ☐ no

☐ psychotherapy ☐ physical therapy ☐ occupational therapy ☐ speech therapy ☐ vision therapy
☐ nutritional therapy ☐ behavioral therapy ☐ other _____

If yes please list duration, location & frequency.

Does your child attend daycare, school or other program? ☐ yes ☐ no

If yes, where and when?

If no, what is his / her daily schedule? Who is home with him / her?

Birth History

Were there any complications during pregnancy? (e.g. gestational diabetes, preecplamsia, premature labor)

☐ yes ☐ no

If yes, please explain.

Did mother take any medication during pregnancy? ☐ yes ☐ no

If yes, what were they and why were they taken?

Where was your child born? ☐ hospital ☐ birthing center ☐ home

If hospital or birthing center, please name the facility:

Type of delivery: ☐ vaginal ☐ cesarean

Term: _____ weeks Birth weight and length: _____

Mother's age: _____ Father's age: _____ # days in hospital _____

Were there any complications during birth? ☐ yes ☐ no

☐ premature birth ☐ breathing difficulty ☐ incubation

☐ jaundice ☐ transfusion ☐ forceps

☐ feeding difficulty ☐ suction ☐ congenital defects

☐ emergency cesarean ☐ tube fed ☐ low APGAR

☐ other complications (please explain)

Was your child in the NICU? ☐ yes ☐ no

If yes, why and for how long?

The following is a list of infant behaviors. Please check all that apply to your child as an infant:

☐ cried a lot, fussy, irritable ☐ resisted being held ☐ good, non-demanding

☐ floppy when held ☐ alert ☐ tense when held

☐ quiet or passive ☐ very active ☐ liked being held

☐ good sleep patterns ☐ drooled excessively ☐ irregular sleep patterns

Developmental History

How old was your child when he/she first:

rolled over: _____ sat independently: _____

crawled: _____ pulled to stand: _____

walked independently: _____ talked (single word): _____

spoke in sentences: _____

Nutritional History

☐ breast fed how long? _____ any difficulties? _____

☐ bottle fed how long? _____ any difficulties? _____

Has your child experience any of the following?

☐ colic ☐ food allergies ☐ sucking / latching problems

☐ growth / nutritional problems ☐ GERD / reflux

☐ other feeding problems

Age of transition to:

cereal: _____ solids: _____

finger foods: _____ table foods: _____

Did your child experience any difficulty during these transitions? ☐ yes ☐ no

If yes, please explain.

Does your child use utensils? ☐ yes ☐ no

Does your child currently experience any difficulties with feeding?

☐ spitting up ☐ refusal to eat

☐ fussy eater ☐ overeating

☐ other feeding problems

Does your child experience difficulties with:

☐ biting food ☐ chewing food ☐ other _____

☐ moving food around in the mouth ☐ swallowing food

If yes, please explain.

Self-Care

Does your child participate in getting dressed? ☐ yes ☐ no

Does your child require assistance to:

☐ put on / take off their shirt ☐ pull up / take off pants ☐ put on / take off socks

☐ put on / take off shoes ☐ tie shoes ☐ fasten snaps / pull apart snaps

☐ button or unbutton ☐ pull a zipper up or down ☐ use a buckle

☐ use Velcro fasteners

Please describe:

Is your child toilet trained? ☐ yes ☐ no

Do toileting accidents occur? ☐ yes ☐ no

If yes, what time of day do the accidents typically occur?

Does your child experience difficulty participating in any of the following activities?

☐ brushing teeth ☐ brushing hair ☐ trimming nails

☐ taking a bath ☐ taking a shower ☐ getting his / her face wet

Please describe:

Sleep Patterns

Does your child experience any difficulty falling asleep? ☐ yes ☐ no

What time does your child go to bed for the night? _____

What time does your child wake up in the morning? _____

Does your child sleep through the night? ☐ yes ☐ no

If no, how many times does he / she wake up during a typical night? _____

Does your child nap during the day? ☐ yes ☐ no

If yes, how many naps per day? _____

What time does your child go down for a nap?_____

Duration of nap?_____

Medical History

Does your child have any medical diagnoses? ☐ yes ☐ no

If yes, please explain:

Has your child had any of the following? Please check all that apply.

☐ frequent colds / respiratory illness	☐ frequent strep throat / sore throat	☐ birth defect / genetic disorder
☐ lung condition / respiratory disorder	☐ frequent ear infections (tubes?)	☐ allergies or asthma
☐ heart condition	☐ anemia / blood disorder	☐ kidney / renal disorder
☐ hormonal problem	☐ urinary problems / infections	☐ muscle disorder / problem
☐ joint or bone problem	☐ fractured bones	☐ skin disorder / problem
☐ visual disorder / problem	☐ eye infection	☐ neurological disorder
☐ seizures or convulsions	☐ stomach disorders	☐ vomiting / digestion problems
☐ failure to thrive	☐ feeding problems	☐ constipation
☐ diarrhea problems	☐ hearing loss / ear disorder	☐ significant accidents / trauma
☐ head injuries / concussions	☐ ingestion of toxins, poisons or foreign objects	

Has your child had any major medical procedures / surgeries? ☐ yes ☐ no

If yes, please provide the date and results given.

Has your child taken any medication for longer than 30 days / is your child taking any maintenance medications?
(please list medication, time of day it is taken and what it is treating)

Has your child had any major medical illnesses (e.g. chickenpox, hand, foot and mouth, croup, etc.):

Has your child received all of the vaccinations recommended by your pediatrician? ☐ yes ☐ no

If no, please explain.

Has your child been hospitalized? (Please list date and reason)

Has your child had a hearing test? ☐ yes ☐ no

If yes, please list date of test and results?

Has your child had an eye exam? ☐ yes ☐ no

If yes, please list date of test and results?

Does your child wear glasses? ☐ yes ☐ no

Behavioral History

Does your child experience difficulty following directions at home? ☐ yes ☐ no

If yes, what is his / her typical response?

Does your child experience difficulty with any of the following:

☐ transitioning away from a preferred activity

☐ transitioning from one activity to another

☐ dealing with unexpected change in routine

☐ transitioning from one environment to another

☐ transitioning from one caregiver to another

If yes, what is his / her typical response?

Does your child become frustrated easily? ☐ yes ☐ no

If yes, what does he / she do?

Does your child have friends? ☐ yes ☐ no

Does your child play with other children? ☐ yes ☐ no

What does your child enjoy doing?

Does your child use toys the same way each time play occurs or is his / her play routine constantly changing and evolving? Please describe.

Educational History

*Please complete the following **only** if your child attends preschool, kindergarten or elementary school.*

name of current school: _____

school address: _____ school phone: _____

_____

teacher's name: _____ email: _____

Does your child have an Individualized Education Plan (IEP)? ☐ yes ☐ no

If yes, what service(s) does he / she receive?

If your child is in private school, does he / she receive any Special Education Services? ☐ yes ☐ no

If yes, what service(s) does he / she receive?

Has your child's teacher expressed any concerns with you regarding your child? ☐ yes ☐ no

If yes, please describe.

Thank you!