Pediatric Therapy Studio

Occupational Therapy Intake Form

Pediatric Therapy Studio requests this information for the purpose of completing a thorough evaluation with your child. Depending on your child's abilities, some questions may not be applicable.

General Information:

Last Name: _____ **First Name:** _____

D.O.B: _____ **Age:** _____ **Gender:** M F

Address: _____

Cell Number: _____ **Email:**_____

Mother's full name: _____

Father's full Name: _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other_____ Phone _____

Address _____ City _____

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

o Yes o No

Person Providing Information Date: _____

Is there any known history of the following in the immediate or extended family?

- o Autism/PDD
- o ADHD
- o Learning Disabilities
- o Hearing Loss
- o Stuttering
- o Speech/Language Delays

Evaluation & Therapy Services:

Please list any previous occupational therapy evaluations completed and recommendations:

_____

_____

Please list any previous psychological/neuropsychological/psych-educational evaluations completed and recommendations:

_____

_____

Concerns:

1. When did you first have concerns about your child?

_____

_____

_____

2. What made you concerned?

_____

_____

_____

3. What strategies or techniques have you been trying independently?

_____

_____

_____

4. What is your primary concern today?

_____

_____

_____

5. What specific skills would you like your child to achieve in therapy?

_____

_____

_____

Pregnancy and birth history:

1. Were there any illnesses, injuries, bleeding, or other complications during your pregnancy?

_____

_____

2. Was your pregnancy full term? If not, please give gestational age.

_____

3. Was labor and delivery normal?

_____

_____

4. What was your method of delivery (vaginal, breech, cesarean)? Were forceps or suction used?

_____

_____

5. Was oxygen or respiratory assistance required after birth? Yes / No (If yes, please explain)

_____

_____

6. Did you experience any complications with feeding? Yes / No (If yes, please explain)

_____

_____

7. How was your child fed as an infant and until what age? Bottle / Breast Age:

_____

_____

8. Please list any concerns regarding your child's eating habits.

_____

_____

_____

Medical history:

1. Has your child experienced any of the following? (Please check all that apply)

- Chicken Pox
- Seizures
- Frequent ear infections or fluid in the ears
- Cleft Palate/Lip
- Gastroesophageal Reflux
- PE Tubes (If so, when?) / /
- Vision Problems
- Feeding Tube (If so, when?) / /

2. Is your child currently taking any medications? (If yes, please list)

_____

_____

3. Does your child have any known food allergies? (If yes, please list)

_____

_____

4. Has your child's hearing been evaluated recently? (If yes, when, by whom and what were the results?)

_____

_____

5. Are there any other precautions we should know about that are not described above?

_____

_____

Developmental History:

Feeding:
Does your child have any feeding difficulty with the following:

- Poor suck
- Difficulty swallowing
- Difficulty chewing
- Gag/choke often
- Finger feeding
- Spoon use
- Required a feeding tube
- Reflux/vomiting

Is your child a picky eater? Y / N
Does your child dislike particular textures of food? Y / N

List any other feeding concerns:

_____

_____

Developmental History:
Fill in the blanks to describe your child to the best of your ability:

Sat at ___months/years
Crawled at ___months/years
Stood at ___months/years
Walked at ___months/years
Ran at ___months/ years
Talked at ___months/ years
Dressed at ___months/ years
Toilet trained at ___months/ years
Fed self ___months/years
___Was not placed on belly as an infant ___Was placed on belly as an infant
___Enjoyed belly time as an infant ___Did not tolerate belly time as an infant
___Is athletic/ plays sports
___Is good negotiating playground equipment
___Met all motor milestones on time ___Is good with his/her hands (fine motor skills)
___Was/is developmentally delayed ___
Was late to _____
___Is clumsy ___Avoids climbing, swinging, sliding

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc…):

_____

_____

_____

Hearing/Vision:

Has your child ever had a vision test? Y / N Does your child wear glasses? Y / N
If yes, last date performed_____

Results:

_____

Has your child ever had a Hearing test? Y / N If yes, last date performed_____

Results:

_____

Does your child wear a hearing aide? Y / N
If yes, please indicate Left_____ Right_____

Sensory History:

Do your child's hands, feet, and or tummy seem overly sensitive to touch? Y / N

Does your child seem distractible or overactive? Y / N

Does your child tolerate tooth brushing?	Yes	No
Does your child hesitate on uneven surfaces?	Yes	No
Does your child have difficulty positioning him/her in a chair?	Yes	No
Does your child push/bump into other children?	Yes	No
Does your child seem generally weak?	Yes	No
Does your child have difficulty judging the height/depth of stairs?	Yes	No
Does your child walk/go down stairs heavily (stomping feet)?	Yes	No
Does your child have difficulty participating in group sports?	Yes	No
Does your child have a fear of using playground equipment?	Yes	No
Does your child have difficulty catching him/her when falling?	Yes	No
Does your child not hear certain sounds?	Yes	No
Does your child respond negatively to certain sounds?	Yes	No
Does your child seem to be a picky eater?	Yes	No
Does your child seem to always seek activities with pushing, pulling, jumping?	Yes	No
Does your child demand only to wear certain clothes all the time?	Yes	No
Does your child avoid getting hands messy?	Yes	No
Does you child get bothered by face washing, hair brushing?	Yes	No
Does your child spin, rock or hit self when distressed?	Yes	No
Does your child have difficulty keeping eyes on task/activity?	Yes	No

Emotional:

Does your child have difficulty accepting changes in routine?	Yes	No
Does your child get easily frustrated?	Yes	No
Is you child often impulsive?	Yes	No
Does your child have function best in small group or individually?		
Does your child have variable and quickly changing moods; prone to outbursts and tantrums?	Yes	No
Does your child prefer to play on the outside, away from groups, or just be an observer?		
Does your child avoid eye contact?	Yes	No
Does your child have difficulty appropriately making needs known?	Yes	No

Play:

Does your child have difficulty with imitative play (over 10 months)? Yes No

Does your child wander aimlessly without purposeful play or exploration (over 15 months)? Yes No

Does your child need adult guidance to play, difficulty playing independently (over 18 months)? Yes No

Does your child participate in repetitive play for hours; i.e., lining up toys cars, blocks, watching one movie over and over etc.? Yes No

Self-Regulation:

Does your child have excessive irritability, fussiness or colic? Yes No

Does your child calm or soothe self through comfort object? Yes No

Does your child wake up distressed? Yes No

Does your child require excessive help from caregiver to fall asleep; i.e., rubbing back or head, rocking, long walks, or car rides? Yes No

Please list any Behavioral Issues_____

Are their any Behavioral strategies being used?

_____

Language Skills:

What is your child's primary mode of communication (gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange)?

_____

_____

1. If your child is talking, please indicate at what age your child began to:

   _____ Babble _____ First Word

   _____ 2-3 word phrases _____Use language as primary mode of communication

2. Please give an estimate of how many words are in your child's vocabulary.

   Receptive (words understood): _____

   Expressive (words spoken): _____

3. Does your child:

   - Answer questions logically? Yes / No / Sometimes
   - Greet people arriving or leaving? Yes / No / Sometimes
   - Engage in turn taking? Yes / No / Sometimes
   - Initiate conversation? Yes / No / Sometimes
   - Maintain a topic? Yes / No / Sometimes
   - Recall & tell about everyday events? Yes / No / Sometimes
   - Follow one-step directions? Yes / No / Sometimes

4. What are some of your child's favorite toys/interests?

_____

_____

Education:

1. Does your child attend school? If yes, where and how often?

_____

_____

2. What grade is your child presently in?
   _____

3. Please list any services your child receives at school (speech, occupational therapy, physical therapy, tutoring, etc.).

_____

_____

4.Does your child experience any specific challenges in school? (Please explain)

_____

_____

Thank you for taking the time to complete this form. We look forward to working with your child and family.