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OCCUPATIONAL THERAPY INTAKE (0-21 YRS)

1. PERSONAL INFO

Name: _____ Caregiver: _____

Address: _____

Date of Birth: _____ Phone numbers: _____

2. MEDICAL HISTORY

Why is the child being seen? (chief concerns)

Has the client received occupational therapy evaluation prior to this visit? If so, where?

☐ Yes _____ ☐ No

Please describe the child's birth, delivery, mom's health/state during the pregnancy, info regarding birth: (mention any abnormal Apgar scores, extended hospital stays, complications, length of pregnancy- weeks, etc)

Has the client been hospitalized? ☐ Yes ☐ No (Include dates & any surgeries)

Reason for hospitalization	Date

Detail any important medical diagnoses or conditions, including vaccination history and approx dates :

Medical condition/diagnoses	Date

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2. MEDICAL HISTORY *(CONTINUED)*

What helps or worsens your child's condition? (ex: time of day, seasons, being alone, etc)

List any allergies or food intolerances

Allergies	Food Intolerances	Reaction (ex: hives, throat closes,etc)

List medication, remedies, vitamins, supplements and frequency taken:

Name	Dose	Name	Dose

Has your child taken antibiotics?

☐No ☐Yes For? Frequency? _____

List frequently consumed foods (ex: food addictions, child must drink milk daily, only eats goldfish, craves pickles, etc):

List any traumas the child has experienced (this could be mental, physical, etc)

Detail	Date

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3. FAMILY MEDICAL HISTORY

Mention IMPORTANT physical disorders, disease history, mental illnesses, etc

Mother:
Maternal grandmother:
Maternal grandfather:
Father:
Paternal grandmother:
Paternal grandfather:

4. TREATMENTS

Professionals currently treating child:

- ☐ Pediatrician
- ☐ Neurologist
- ☐ Nutritionist/Registered Dietician
- ☐ ENT/Audiologist
- ☐ Physical Therapist
- ☐ Speech Therapist
- ☐ Occupational Therapist
- ☐ Developmental Optometrist
- ☐ ABA/Behavioral Therapists
- ☐ Special Educators

☐ Other Specialists (list below)

_____

_____

Vision Screening? ☐ Yes ☐ No

Identified deficits:

Hearing Screening? ☐ Yes ☐ No

Identified deficits:

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5. SYMPTOMS

Please check any of the child's symptoms or traits below that were/are of concern:

- ☐ Anxiousness
- ☐ Fussy as baby
- ☐ Obstinate/Stubborn
- ☐ Rigid/Inflexible (mental)
- ☐ Extemely Overactive
- ☐ Resists touch input
- ☐ Aggressive
- ☐ Difficult to calm
- ☐ Leans on wall to stand
- ☐ W-Sits
- ☐ Sleeps a lot
- ☐ Difficulty falling asleep
- ☐ Wakes in night @ _____
- ☐ Night Terrors
- ☐ Destroys play items/Forceful
- ☐ Teeth brushing aversion
- ☐ Hair brushing aversion
- ☐ Solitary play only
- ☐ Plays with younger kids
- ☐ Prefers adults in play
- ☐ Haircut avoidance
- ☐ Fearful ascending stairs
- ☐ Fearful descending stairs
- ☐ Toe walking
- ☐ Mouth-breather
- ☐ Easily fatigued
- ☐ Fearless/daredevil
- ☐ Climber
- ☐ Hyper-sensitive ears
- ☐ Incoordinated/clumsy
- ☐ Self-abusive/injurious behaviors
- ☐ Easily startled
- ☐ Withdraws from touch
- ☐ Resists new environments
- ☐ Shy/Withdrawn
- ☐ Hoards toys/objects
- ☐ Gazes at/Talks of spinning objects
- ☐ Spins items/self
- ☐ Obsessed w/ _____
- ☐ Hand flapping
- ☐ Facial tics/grimacing
- ☐ Low muscle tone
- ☐ Teeth grinding
- ☐ Lines up toys/objects
- ☐ Easily angered
- ☐ Abusive toward caregivers
- ☐ Demanding/impatient
- ☐ Props body for support/ head on hands
- ☐ Rigid body movements
- ☐ Delays with motor development
- ☐ No filter/tactless
- ☐ OCD/repetitive behaviors
- ☐ Socially awkward
- ☐ Leader/dominant/alpha
- ☐ Pacing/ perimeter walking
- ☐ Lazy/ Doesn't expend energy
- ☐ Cautious
- ☐ Tuned out/ Zoned out
- ☐ Language delays
- ☐ Speech articulation delays

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5. SYMPTOMS *(CONTINUED)*

- [ ] Low self-esteem/ Confidence issues
- [ ] Difficulty with transitions
- [ ] Hyper-focused
- [ ] Threatens others verbally
- [ ] Everything's unfair
- [ ] Vaccine-injured
- [ ] Oppositional/Defiant
- [ ] Unpredictable
- [ ] Predictable/Rigid with routines
- [ ] Seizures/History of
- [ ] Ear infections/Tubes placed
- [ ] Pertussis/Whooping cough
- [ ] Measles or mumps
- [ ] Chicken pox/varicella
- [ ] Herpes complications
- [ ] Psoriasis
- [ ] Eczema
- [ ] Ringworm
- [ ] Skin picking
- [ ] Pulling out hair
- [ ] Not toilet-trained
- [ ] Extreme holding of urine/feces
- [ ] Eats/licks inedible objects/items
- [ ] Definite/ Consistent fears
- [ ] Cannot remain still
- [ ] Gut issues - Colic
- [ ] Gut issues - Worms/Parasites
- [ ] Gut issues - Diarrhea
- [ ] Gut issues - Constipation
- [ ] Gut issues - Nausea/vomiting
- [ ] Food aversions
- [ ] Food allergies
- [ ] Extremely limited diet
- [ ] Thirstless
- [ ] Overly thirsty

Please describe specifics regarding the above concerns (ex: OCD- she must open every blind at night before going to bed; his low muscle tone makes him lean against wall for support while standing, she obsesses over spinning toilet water, watches ticking, ceiling fans, and overruns conversations about these subjects, etc) Your descriptive statements assist your therapist significantly.