Speech Language Pathology & Occupational Therapy Practice
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Occupational Therapy Intake #1

General Information:

Name: _____ Date of Birth:_____

Address: _____ Phone: _____

City: _____ Zip Code: _____

Does the child live with both parents? _____

Mother's Name: _____ Age: _____

Mother's Occupation: _____ Cell Phone: _____

Mother's email address: _____ Home Phone: _____

Work Phone: _____

Level of school completed (circle one): *high school* *college* *graduate degree*

Father's Name: _____ Age: _____

Father's Occupation: _____ Cell Phone: _____

Father's email address: _____ Home Phone: _____

Work Phone: _____

Level of school completed (circle one): *high school* *college* *graduate degree*

Referred by: _____

Pediatrician: _____ Phone: _____

Address: _____

Brothers and Sisters (include names and ages):

Others living in the home (include phone and email address where appropriate (e.g. babysitters, etc.):

What languages does your child speak? What is your child's dominant language and are any other language spoken at home?

With whom does your child spend most of his or her time?

Describe your child's current sensory and/or motor challenge(s).

What are your child's strengths?

When was the problem first noticed? By whom?

Has the problem changed since it was first noticed?

Is your child aware of the problem? If yes, how does he or she feel about it?

Have any other occupational therapists seen your child? Who and when? What were their conclusions or suggestions? Please provide evaluation reports if applicable.

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen your child? If yes, indicate the type of specialist and when the child was seen. Please provide a copy of evaluation reports.

Please provide a chronology of services obtained (i.e., Birth to Three, preschool, public school, etc.)

Are there any other sensory, motor, learning, or psychiatric problems or disabilities in your family? If yes, please describe.

Please list other services your child currently receives (i.e., speech therapy, physical therapy, etc.)

Prenatal and Birth History

Mother's general health during pregnancy (illness, accidents, medications, etc.)

Mother's general health prior to pregnancy (food allergies, auto immune disorders, etc.)

Length of pregnancy: _____ Length of labor: _____

General condition: _____ Birth weight: _____

NICU stay/duration (if applicable): _____

Type of delivery (circle): *head first* *feet first* *breech* *Caesarian*

Were there any unusual conditions that may have affected the pregnancy or birth?

Were there any difficulties in the following areas (circle): *feeding* *latch* *colic* *sleep*

Describe any challenges your child experienced as an infant.

Medical History
Has your child experienced the following illnesses and conditions? If so, at what age?

Asthma _____	Chicken pox_____	Colds _____
Croup _____	Dizziness _____	Draining ear _____
Ear infections _____	Encephalitis _____	German measles _____
Headaches _____	High fever _____	Influenza _____
Mastoiditis _____	Measles _____	Meningitis _____
Mumps _____	Pneumonia _____	Seizures _____
Sinusitis _____	Tinnitus _____	Tonsillitis _____

Other
_____

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

Does your child have any allergies? If yes, identify.

Is your child on a special diet? If yes, describe.

Developmental History

Provide the approximate age at which the child began to do the following activities:

Rolled _____Crawl _____ Sit _____

Stand _____Walk _____ Feed self _____

Dress self _____Use toilet _____

Describe your child's ability in the following areas:

Hand preference/grasp _____

Manage containers (e.g., open/close) _____

Manage snaps/zippers _____

Manipulate utensils _____

Self-feed (e.g. use hands/spoon/fork,etc.)_____

Do you recall anything remarkable with regards to development (i.e., loss of words, anxiety, etc.)?

Are there or have there ever been any feeding problems (e.g., problems with latch, sucking, swallowing, drooling, chewing)? If yes, describe.

Describe your child's current eating habits (e.g., food intake, preferences, refusals).

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds).

Do you find your child to be anxious, sad, or irritable?

How does your child sleep? What are typical patterns/routines?

Does your child exhibit any unusual behaviors or have unusual interests?

How does your child handle transitions and/or change in routine?

What strategies does your child use to regulate when they are upset? How long do they typically take to recover?

Sensory Motor Skills

Please check any statements that describe your child:

___Appears clumsy

___Walks on his/her toes

___Bumps into walls, furniture, and/or other people

___Unaware of being touched unless with force

___Slumps, slouches when sitting

___Has difficulty learning new motor tasks (e.g., riding bike, yoga positions, dance moves)

___Unaware that face and hands are dirty

___In constant motion

___Chews on toys, shirts, non-food objects

___Invades space of others

___Sensitive to noise, smell, sound, taste (Provide any additional info_____)

___Avoids touching certain textures

___Avoids messy play (paints, slime, play dough, mud)

___Only eats certain texture foods

___Resists grooming (brushing teeth, hair, washing hair, etc.)

___Is fearful on playground

___Plays with the same toys/activity or resists change in play

___Appears fearless

___Presents as sluggish or sedentary

Educational History

School: _____ Grade: _____

Teacher(s): _____

How is your child doing academically (or pre-academically)?

How does your child interact with others (e.g., shy, aggressive, uncooperative)?

Number of regular playmates: _____ Ages: _____ Genders: _____

Activities shared with parents and siblings: _____

How does your child handle frustration: _____

conflict: _____ separation: _____

Regular responsibilities: _____

Favorite places: _____ people: _____

toys: _____ snacks: _____

activities: _____ TV programs: _____

What motivates your child most? _____

What discipline methods work best? _____

If enrolled for special education services, has an Individualized Educational Plan (IEP), or another specialized plan been developed? If yes, what services are included? Please provide copy of IEP or plan.

Please provide any additional information that might be helpful:

Person completing form: _____ Relationship to client: _____

Signed: _____ Date: _____