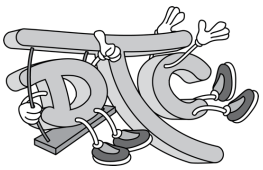

Developmental Therapy Center

Occupational Therapy Intake Form

Date: _____/_____/_____
Month Day Year

Client Information

Client Name: _____ Sex: ☐ Male ☐ Female ☐ Intersex

Birth Date: _____ /_____ /_____ Age: _____
Month Day Year

General

Please describe the concerns regarding your child that brought you here today:

Tell us about your understanding of your child's condition or development as it relates to occupational therapy:

With the above information in mind, what do you see as your child's biggest barriers at this time?

Feeding

Is feeding or eating an area of concern that affects your child's daily life? If yes, please list your child's typical diet:

Was your child breastfed? If so, for how long?

Does your child have difficulty with the act of eating? If so, please describe:

Does your child exhibit oral sensitivities or oral seeking behaviors (e.g. examines objects by placing in mouth, gags/vomits frequently, bites/chews objects or clothing frequently, grinds teeth)?

Sleeping

Please describe any concerns you have regarding your child's sleep (e.g. falling asleep, staying asleep, awakening at night) If so, what helps your child return to sleep?

How old was your child when s/he consistently slept through the night?

Grooming

Does your child dislike or resist grooming activities? Check all that apply:	☐ Tooth Brushing ☐ Bathing ☐ Hair brushing/ combing ☐ Face Washing ☐ Haircuts ☐ Nail Trimming ☐ Hand washing

Which grooming activities can your child complete independently?

Are grooming activities an area of concern? If so, what helps your child to best tolerate grooming activities?

Dressing

Which clothing is your child able to take off independently? Check all that apply:	☐ Shirt ☐ Pants ☐ Underwear ☐ Shoes ☐ Socks ☐ Coat
Which clothing is your child able to put on independently? Check all that apply:	☐ Shirt ☐ Pants ☐ Underwear ☐ Shoes ☐ Socks ☐ Coat
Which fasteners can your child manage independently? Please check all that apply:	☐ Snaps ☐ Zippers ☐ Buttons

Can your child tie his/her shoes?

Is your child selective in the types of clothing he/she will wear? If so, what types of clothing are preferred and what types are avoided?

Toilet Training

Is your child bowel or bladder trained?

Please describe any concerns you have regarding toileting:

Fine Motor/Gross Motor Skills

Child's Hand Preference	☐ Right ☐ Left	Child's Foot Dominance	☐ Right ☐ Left

Does your child have difficulty with any of the following skills? (school-aged children) Check all that apply:	☐ Sitting still ☐ Standing in line ☐ Tolerating noises ☐ Paying attention to a story being read ☐ Keeping eyes too close to work ☐ Closing/covering one eye while doing work ☐ Copying from chalkboard to paper ☐ Losing place often during reading ☐ Eye strain after reading ☐ Handwriting ☐ Reverses letters or words ☐ Uses too much or too little pressure when drawing/writing ☐ Doesn't look when manipulating objects Ball skills: ☐ throwing ☐ catching ☐ kicking ☐ Balance

Please describe any additional concerns related to fine motor and gross motor skills below:

Family Living/Community

Is your family limited in activities (social gatherings, eating at restaurants, going to the grocery store, participating in hobbies, etc.) because of your child's behavior or preferences? Please explain:

What does your family enjoy doing?