INTAKE FORM

Patient's Name: _____ Today's Date: _____
Patient Date of Birth: _____ Age: _____ Gender Identity: _____
Person Completing Form: _____ Relationship to Patient: _____
Telephone Number: _____ Referred By: _____

CONTACT INFORMATION

Patient's Legal Guardian/s: _____
Relationship to Patient: _____
Address: _____
Street City State Zip Code

Telephone Number: _____ { Cell Phone/Home Phone }

Email Address: _____

Emergency Contact: _____ Telephone Number: _____

Languages spoke at home: _____

Best form of contact: (Please Circle One) Email Phone

INSURANCE INFORMATION

Insurance Company: _____
Policy Holder: _____ Policy Holder's DOB: _____
Member ID: _____ Group ID: _____
Send Claims to: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____

BACKGROUND INFORMATION

Reason for seeking occupational therapy evaluation or services:

_____
_____
_____
_____
_____
_____

What would you like to learn from this evaluation?

What are your child's strengths? What does s/he like to do?

What is your primary concern for your child at this time? What tasks are difficult for your child to perform?

What would you like to be easier for your child and/or your family?

OCCUPATIONAL PERFORMANCE
EDUCATION/SCHOOL

Child's School: _____

Phone#: _____

Teacher(s): _____ Grade: _____

Do you have concerns regarding school? If yes, please specify.

Does your child's teacher(s) have any concerns? If yes, please specify.

PLAY

Describe your child's preferred play activities and/or toys. What does your child do with the toys s/he enjoys?

SOCIAL PARTICIPATION

Does your child enjoy playing with peers or siblings, prefer solitary play, or prefer adult interaction?

DEVELOPMENTAL AND MEDICAL HISTORY

Child's Primary Care Pediatrician (PCP):

Phone#: Fax#:

Referring Physician (if different than PCP):

Has your child been diagnosed as having any medical or educational conditions? If yes, please describe and provide records.

Please describe your child's birth history and early life. Has your child experienced separation from birth family, adoption, or other early stressors or trauma?

Does your child have any allergies? If yes, please list and describe the severity.

_____

_____

_____

_____

Has your child seen any of the following specialists?

Specialty	Name of Agency/Provider	Date Started	Ongoing or Completion Date
Occupational Therapy			
Speech Therapy			
Physical Therapy			
Ophthalmology/Vision Test			
Audiology/Hearing Test			
Mental Health (counseling/psychology/ psychiatry)			
Other			

Is your child presently taking any medication? If yes, please list and state reason and frequency.

_____

_____

_____

_____

Check each option that describes your child as an infant:

- ☐ Fussy
- ☐ Passive
- ☐ Resisted being held
- ☐ Good Sleep Patterns
- ☐ Quiet
- ☐ Liked being held
- ☐ Tense when held
- ☐ Overactive/rarely still
- ☐ Irritable
- ☐ Active
- ☐ Floppy when held
- ☐ Irregular sleep pattern

General impression of child's development:
Gross motor: ☐ Slow ☐ Normal ☐ Advanced
Fine Motor: ☐ Slow ☐ Normal ☐ Advanced
Feeding: ☐ Slow ☐ Normal ☐ Advanced
Language: ☐ Slow ☐ Normal ☐ Advanced
Social/Emotional: ☐ Slow ☐ Normal ☐ Advanced

Check all that describe your child presently:

☐ Mostly quiet
☐ Wets bed
☐ Fights frequently
☐ Difficulty learning new tasks
☐ Poor attention span/concentration
☐ Overly active
☐ Restless
☐ Overreacts
☐ Tires easily
☐ Talks constantly
☐ Difficulty following directions
☐ Nervous habits/tics

Does your child tantrum? Yes or No
Does your child bang his/her head or perform other self-abusive behaviors? Yes or No
If yes, please describe these behaviors in more detail:

Please provide us with any other information that you feel is important for us to know about your child: