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OCCUPATIONAL THERAPY INTAKE / DEVELOPMENTAL HISTORY

Thank you for your time to complete this form. It is lengthy, but is an important part of designing an individualized OT program for your child. This information provides the Occupational Therapist with complete and detailed information about your child and your concerns.

Child's Name: _____

Birth Date: _____
Form Completed By: _____
Address: _____ Home Phone: _____
_____

Child's Handedness: Right Left Ambidextrous No Preference Not yet developed

Parents are: Married Separated Divorced Windowed Single Other

Child lives with _____ (include relationship)

Is child adopted or in foster care? _____

Parent/ Guardian Name: _____ Cell Phone: _____
Email: _____
Occupation: _____

Parent/ Guardian Name: _____ Cell Phone: _____
Occupation: _____
Email: _____

Names and Ages of Brothers and Sisters: _____
Emergency Contact: _____

Referred By: _____
Address: _____ Phone: _____
_____

Pediatrician: _____
Address: _____ Phone: _____
Medical Diagnosis: _____
_____

Current Medications/ Supplements: _____
_____

Current Precautions or Allergies: _____
_____

Results of Hearing or Vision Tests: _____
_____

Other Pertinent Medical Information: _____
_____
_____

School: _____ Grade: _____
Teacher: _____ Classroom Type: _____
Child has IEP? Yes No
Date of IEP Annual Review: _____ Date of 3 - year
Reevaluation: _____ List Special Education Services
and Service Providers:
_____
_____
_____

Your perspective on current issues or concerns related to home
_____
_____
_____
_____

Your perspective on current issues or concerns related to school:
_____
_____
_____
_____

Your perspective on current issues or concerns related to peers/ extra-curricular activities:
_____
_____
_____
_____

Please list any therapies or services your child receives outside of school and providers:
_____

_____
_____
_____

PRIMARY CONCERNS:
What do you hope to gain from OT evaluation & treatment?

_____
_____
_____
_____
_____

What are your child's gifts and strengths?

_____
_____
_____
_____
_____

What concerns you most about your child?

_____
_____
_____
_____
_____

Are there any problems with daily routines?

_____
_____
_____
_____

What particular skills would you like your child to gain in the next 6 months?

_____
_____
_____
_____

Is this your first evaluation for this concern? _____
If not, please list other evaluations and general results (agency, date, outcome):

_____
_____
_____
_____

PRENATAL / BIRTH HISTORY:
Was the pregnancy full term? Yes No If no, gestational age at delivery: _____
Weight at birth: _____
Any unusual illnesses during pregnancy? Yes No
If yes, please list: _____
Was labor induced? Yes No
Was birth by C-Section? Yes No
Were forceps used during delivery? Yes No
Complications during delivery: _____
Birth Injuries: _____

INFANCY AND EARLY CHILDHOOD:
Please describe any feeding problems:
_____
_____
Please describe any sleeping problems:
_____
_____
Did your child experience colic? Yes No
Did your baby dislike lying on stomach? Yes No
Did your baby dislike lying on back? Yes No
Did your baby become calmed by car rides or infant swings? Yes No Did your baby become upset by car rides or infant swings? Yes No

DEVELOPMENTAL MILESTONES (please list age if remembered):
Roll Over _____ Sit alone _____
Crawling _____ Walking _____
Chew solid food _____ Drink from a cup _____
Say words _____ Say sentences _____

CURRENT MOTOR PERFORMANCE: A = Always S = Sometimes NY = Not yet

	A	S	NY	COMMENTS
Picks up small objects				
Points to an object				
Uses writing utensils				
Feeds self with utensils				
Brushes teeth independently				
Dresses him / herself				

Ties shoes independently				
Wipes self after toileting				
Jumps with 2 feet together				
Skips with both feet				
Swims w/ crawl or other strokes				
Pumps self on swing				
Kicks a ball				
Catches a ball				
Turns pages of a book				
Rides tricycle/training wheels				
Rides a bicycle				
Blows a whistle				
Cuts with scissors				
Colors inside lines				
Cuts food with a knife				

COMMUNICATION SKILLS: A = Always S = Sometimes NY = Not Yet

	A	S	NY		COMMENTS
Speech understood by stranger					
Communicates with gestures					
Communicate with vocalization					
Communicate with single words					

Communicates with phrases				
Communicates with sentences				
Expresses self with sign language/ Picture Symbols				
Complex communication				
Understands familiar utterances				
Understands complex utterance				
Understands story w/out picture				
Understands multistep directions				

BEHAVIOR
Issues at home:

_____
_____
_____
_____

Issues in school:

_____
_____
_____
_____

Management Strategies:

_____
_____
_____

LIKES AND DISLIKES
Things your child seeks out or finds reinforcing (characters, people, shows, songs, toys, books) :

_____
_____
_____
_____

Things your child fears, finds irritating, avoids, or resists:

_____
_____
_____
_____

SOCIALIZATION

Please check all that apply to your child's social behavior:

- shy
- friendly
- very active
- inactive
- demands attention
- withdrawn
- anxious
- craves routine
- poor self-confidence
- frequent tantrums
- trouble separating from parents
- sad or depressed
- Other personality traits and characteristics:

_____

_____

_____

Describe how your child interacts with adults, siblings, and peers:

_____

_____

_____

_____ Scale for following tables:

A = Always, O = Often, S = Sometimes, R = Rarely, N = Never

	A	O	S	R	N	COMMENTS
VISUAL PROCESSING						
Distracted by visual stimulation						
Dislikes eyes covered						
Likes playing in the dark						
Irritated by bright lights						
Trouble following object w/eyes						
Avoids eye contact						
AUDITORY PROCESSING						
Dislikes music or singing						
Has difficulty with rhythms						

Seems sensitive to sounds						
Distracted by noise						
MOVEMENT PROCESSING						
Enjoys swings						
Has good balance						
Enjoys merry go rounds / rides						
Likes being tipped upside down						
Hesitates on climbing equipment						
Hesitates on stairs						
Dislikes elevators / escalators						
Walks on toes						
Jumps on beds & other surfaces						
Bangs head						

	A	O	S	R	N	COMMENTS
Does not alternate feet on stairs						
Spins self around						
Upsets if head tips backwards						
TASTE AND SMELL						
Deliberately smells objects						
Reacts defensively to odors						

Reacts defensively to tastes						
Has trouble eating food w/lumps						
Puts non-food items in mouth						
No response with strong flavors						
TOUCH						
Seems excessively ticklish						
Irritated by tags in shirts						
Dislikes haircuts or shampooing						
Complains of seams in socks						
Discomfort with clothing texture						
Over or under-dress for weather						
Prefers to initiate touch						
Dislikes unexpected touch						
Craves to be held or cuddled						
Overly sensitive to pain						
Underly sensitive to pain						
Constantly touching objects						
Dislikes bathing or showers						

	A	O	S	R	N	COMMENTS
Can’t tolerate water on face						
Pinches, bits, or hurts self						

Avoids messy play						
Dislikes nail cutting						
Tends to bump or push others						
MOTOR SKILLS						
Bumps into things frequently						
Trouble sequencing steps						
Awkward pencil grip						
Poor handwriting						
Weak hands						
Breaks objects frequently						
Drops things easily						
Tires with physical activity						
Deliberately falls or tumbles						
Sloppy eating habits						
Slow to complete motor tasks						
Slow to learn motor tasks						
Reluctant to play sports						
Can’t sit still in chair						
Slumps while sitting						
Has flat feet						
Trouble with eating utensils						
Frequently spills liquids						

	A	O	S	R		N	COMMENTS
Tends to be a slow dresser							
Puts clothing on backwards							

BOWEL AND BLADDER CONTROL
Is your child toilet trained? Yes No If no, please answer the following:

Continue to have accidents during the day until age _____
Continue to have accidents at night until age _____
Has difficulty identifying the need to eliminate? Yes No Does your child show any interest in toilet training? Yes No Please list any concerns or goals in this area:

_____
_____
_____

SLEEP PATTERNS
Does your child have regular sleep patterns? Yes No
Does your child settle to sleep easily at night? Yes No
Does your child have trouble staying asleep? Yes No
Does your child sleep in his or her own bed? Yes No
Is your child an early riser, and immediately on the go? Yes No Is your child slow to wake in the morning? Yes No
What time does your child go to bed? _____
What time does your child wake up on weekdays? _____ on weekends?_____
Please list any concerns or goals in this area:

_____
_____
_____

Please include any other information you would like us to know about your child, which is not contained above. Attach an additional page, if necessary.

_____
_____
_____
_____
_____

Please return this sonal.nyc@gmail.com. Thank you