FUNctional Pediatric Therapy

Occupational Therapy Patient Intake Form

Patient's Information:

Today's Date: _____

Patient's Name: _____ DOB: _____ Age: _____ M/F:_____

Parent/Guardian Name: _____

Home Address: _____ Phone: _____

Email Address: _____

Referral Information:

Who referred this child for an evaluation: _____

Reason for Referral: _____

What are your primary goals/concerns for therapy:

_____

_____

_____

_____

What are you child's strengths:

_____

_____

_____

_____

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School History:

Name of School: _____ Grade: _____ Teacher: _____

Does your child receive special instruction or have an established IEP? YES NO

Does your child receive school-based therapy? (circle all those that apply) OT PT ST

Medical History:

Any difficulties during pregnancy or delivery? YES NO

If yes, please specify:

_____

_____

_____

_____

Length of Pregnancy: _____ Birth was: Vaginal Cesarean Breech

Chronic ear infections: YES NO Tubes placed: YES NO If yes, how many sets of tubes: _____

List Current Medications:

_____

_____

_____

_____

Food Allergies:

_____

_____

_____

_____

Special Diet: _____

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Medical Precautions:_____

Current Diagnosis: _____

Any Hospitalizations: YES NO If yes, date and length of stay: _____

Any Surgeries: _____

Is the patient currently receiving services from any other healthcare provider (Speech, Nutritionist, Behavioral Specialist, etc): _____

Developmental History:

Please specify an age for all the developmental milestones that your child has achieved:

Rolling: _____ Crawling: _____ Sitting alone: _____ Pull-to-stand: _____ Walking: _____

First words: _____ Finger feeding: _____ Eating with spoon: _____ Cutting with scissors: _____

Please check the amount of assistance needed for your child to complete the following tasks:

Self-Care Task:	**Independent** Can complete without assistance	**Moderate Assistance** Requires assistance ~50% of the time	**Maximum Assistance** Requires assistance 75%-100% of the time
Takes pants off			
Puts pants on			
Takes off shirt			
Puts shirt on			
Puts coat on			
Puts hat on			
Buttons			
Zipper			
Snaps			
Puts shoes on			
Takes shoes off			
Ties shoes			
Puts socks on			
Takes socks off			
Toileting			
Bathing Routine			
Brushing Teeth			
Brushing Hair			

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Please describe your child at present:

Descriptor:	Yes:	No:	Sometimes:	Mostly:
Overly Active				
Tires Easily				
Talks constantly				
Acts impulsively				
Restless				
Stubborn				
Resistance to change				
Fights frequency				
Usually happy				
Clumsy				
Exhibits tantrums				
Nervous habits				
Wets the bed				
Poor attention				
Frustrated easily				
Unusual Fears				
Difficulty going to sleep				
Difficulty staying asleep				
Sluggish in the mornings				

Social and Occupational History:

Situation:	Mostly:	Often:	Sometimes:	Rarely:
Socialize with family and close friends?				
Communicate needs and wants effectively?				
Finds it hard to make friends?				
Tends to interact/play with younger children?				
Enjoys time alone?				
Tolerates a change in routine?				
Enjoys eating in restaurants?				
Tolerates running errands?				
Enjoys/wants to attend birthday parties?				
Enjoys/attends family gatherings?				

Anything else you would like us to know about your child:_____

_____

_____

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