Maureen Brady OTR/L

Child/Teen Intake Form

Today's Date: _____

Name of Child/Teen : _____

Nickname: _____

DOB: _____ **Age**: _____

Address: _____

_____

Name of Person Completing This Form:

_____

Relationship: _____

_____

Email address: _____

Home Phone:_____

Cell: _____

Is it ok to leave phone and/or email messages? Yes_____ No_____

Diagnosis (if applicable) and Practitioner who completed evaluation:

_____ _____

What adults does the child live with? Check all that apply.

_____ Birth Parent(s)

_____ Adoptive Parent(s)

_____ Grandparent(s)

_____ Other—Please specify below

_____

Occupational Therapy Intake Form, page 2

Names of the adults the child lives with:

_____

_____

List siblings or other children that reside in the home:

_____ _____

_____ _____

_____ _____

Language Spoken in the Home: _____

Is an interpreter needed for the Occupational Therapy Sessions? _____ Yes _____ No

1). Is individual currently enrolled in a program (daycare, preschool, school)?

_____ Yes _____ No

If yes, list name and address.

_____

Is individual currently receiving OT services or have they in the past?

_____Yes _____No

If yes, please list therapist's name, address and dates and reason for OT.

_____

_____

_____

Occupational Therapy Intake Form, page 3

2). Is individual currently receiving other therapy services (i.e., PT, Speech, Counseling, etc)?

_____ Yes _____ No

If yes, please list the therapy and therapist's name, address.

_____

_____

_____

3). Primary doctor's name and address.

_____

4). Is individual seeing other medical specialists including Naturopaths, etc.?

_____Yes _____No

If yes, list names, address and reason.

_____

_____

_____

_____

5). Are there any medical concerns or restrictions the therapist should be aware of?

_____Yes _____ No

If yes, please explain.

_____

_____

_____

6). Is the individual taking any medications or supplements?

_____Yes _____No

If yes, please list them:

_____
_____
_____
_____

7). Does individual have any food or other allergies?

_____YES _____No

If yes, please list them.

_____

_____

If yes, how were the allergies diagnosed?

_____

8). Birth/Developmental History:

a). How many weeks gestation was the child born?

_____

b). Birth weight? _____

c). Did mother have any increased stress or emotional concerns during or following pregnancy?

____Yes ___ No

If yes, please explain.

_____

_____

d). Was feeding following birth via breast or bottle?

_____

e). Crawl before walking? _____Yes _____No

9). Please list any challenges or stressors happening in individual's life.

_____

_____

_____

_____

10). Please list any fears and/or anxieties or other concerns.

_____

_____

_____

_____

8). Please list desired outcome(s) from the OT sessions.

_____

_____

_____

_____

_____

Printed name of person completing this form:

_____