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Occupational Therapy Intake Form

Today's Date: ______________________

Client Name: ___________________________________ Nickname: ________________________

DOB: ____________ Age: ______________________________

Diagnosis (if known) and Practitioner who completed evaluation:

____ _________________________ _______________

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

_____ Birth Parent(s) _____ Grandparent(s)

_____ Adoptive Parent(s) _____ Other—Please specify below

____

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? _________________________________

Occupational Therapy Intake Form, page 2

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.

____

2). Is individual currently receiving other therapy services (ie speech, counseling, etc)?

_______ Yes _______ No

If yes, please list them 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.

____

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____

____

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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 besides those already listed on SI Questionnaire?

_____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.
____
____

Occupational Therapy Intake Form, page 4

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

e). Crawl before walking? ______Yes ______No

9). Currently are there any unusual changes or stressors happening in individual's life?

______ Yes _______ No

If yes, please explain:

____

____

____

10). Does individual have any fears and/or anxieties? ______ Yes _______ No

If yes, please list them.

____
____
____

8). Please list primary reason(s) for requesting OT and desired outcome(s).
____
____
____
____
____
____

Printed name of person completing this form:

____