Maureen Brady OTR/L

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? _____

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.

_____

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.

_____
_____

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:

_____