Date

_____ / _____ / _____

Parent/Guardian Information

Name: _____

Relationship to child: _____

Email: _____

Phone: _____

Child's Information

First Name: _____

Last Name: _____

Date of Birth: _____ (DD/MM/YYYY)

Age: _____

Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medical History

Primary Diagnosis (if applicable): _____

Other Medical Conditions: _____

Medications (if any): _____

Therapy Services Required

☐ Initial Occupational Therapy Consultation
☐ Ongoing Support and Therapy

Does your child receive any other therapy services? (If yes, please describe)

_____

Areas of Support (Please tick any areas you believe your child might need help with)

☐ Helping with sensory sensitivities (e.g., discomfort with certain textures or sounds)

- [ ] Managing emotions and self-regulation (e.g., dealing with frustration, calming down from excitement)
- [ ] Supporting appropriate levels of arousal and attention (e.g., staying alert and focused, reducing hyperactivity)
- [ ] Improving coordination and movement (e.g., fine motor skills for writing, gross motor skills for playing)
- [ ] Enhancing daily living skills (e.g., dressing, eating, hygiene)
- [ ] Developing social skills and making friends
- [ ] Supporting learning and school activities (e.g., concentration, following instructions)
- [ ] Encouraging play and leisure activities
- [ ] Exploring use of assistive devices or technology
- [ ] Custom support for specific needs (e.g., custom orthotics, specific skill development)

Detailed Concerns and Therapy Needs

If you have specific concerns or are unsure where your child might need support, please share them here:

_____

_____

_____

_____

Availability for Appointments

- [ ] Mornings
- [ ] Afternoons

Funding Information (required)

- [ ] NDIS
- [ ] Private Health Insurance
- [ ] Self-funded
- [ ] Other (Please specify): _____

Additional Information

How did you hear about us? _____

Best time to contact you: _____

Consent for Communication

☐ I agree to sign up for news and updates

Consent for Treatment and Data Use

I, _____ (Parent/Guardian Name), acknowledge that the information provided is accurate to the best of my knowledge.

I consent to the occupational therapy assessment and treatment for _____ (Child's Name) as recommended by the therapists.

I understand that this information will be used to facilitate care and services tailored to my child's needs and will be kept confidential in accordance with privacy laws.

Signature: _____ Date: _____

Upon returning this intake form, please attach any relevant reports, evaluations, or additional information that may assist in providing appropriate services.