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**OT Child Intake Form**

First Name:  Middle Initial:  Last Name: 

Address: City/State/Zip: 

Email address(s): 

Phone #:  Home / Work/ Cell Date of Birth: 

Phone#:  Home / Work/ Cell Social Security #:

Race:  Sex: 

|  |
| --- |
| Emergency Contact:  Phone:  Relationship: |

Primary Care Doctor: Referring doctor: 

Address/Phone#:  Address/Phone#: 

Reason for referral: 

**Insurance information**

Policy holder(s) Name:  DOB: 

Plan Name:  Insurance ID#: 

Secondary Insurance: (leave blank if none)

Plan Name:  Insurance ID#: 

Patient name:  DOB: 

**Motor Development**

Any concerns regarding gross motor skills (i.e., walking up/ downstairs, running smoothly)? Y N

If yes, please explain:



Any concerns regarding fine motor skills (i.e., stacking blocks, drawing, cutting, writing)? Y N

If yes, please explain:



**Social/ Educational** How does your child play?

Please check all that apply:

Prefers to play alone

Prefers to play with 1 or 2 others only

Plays mostly with siblings

Plays mostly with adults

Has a lot of friends

Other- Please explain: 

Is your child able to pay attention as well as most other children his/ her age?

Y N

**Self-help skills**

Any concerns regarding feeding and eating skills (i.e-, using a spoon/ fork, drinking with a straw, food choices, ability to chew swallow)?

Y N

If yes, please explain:



Any concerns about food choices (i.e., selective eater, eats only certain foods or textures)?

Y N

If yes, please explain:



Any concerns regarding dressing skills (i.e., getting dressed/ undressed, managing buttons/ snaps/ zippers, shoe tying)?

Y N

If yes, please explain:



Any concerns regarding hygiene skills (i.e., tooth brushing, bathing, brushing hair)?

Y N

If yes, please explain:

**Sensory motor skills**

## Please check all that describe your child:

## Frequently trips on his/ her own feet

## Walks on his/ her toes

## Frequently bumps into things (i.e., furniture, walls, others)

## Unaware of being touched or bumped in to unless done with extreme force

## Unaware that face/ hands are dirty (i.e., runny nose, food on face)

## Seems unsure of how to move his/ her body; clumsy, not steady on feet

## Slumps or slouches when sitting; places hand on head when sitting

## Has difficulty learning new motor tasks

## Is in constant motion

## Has difficulty sitting still

## Chews on pens, straws, shirt, etc. Frequently touches people and objects

## Frequently gets in the space of others

## Is overly sensitive to touch, noise, smells, etc.

## Avoids touching certain textures / please list:

## Avoids messy play (i.e., finger paints, playdough, mud, sand) Only eats certain foods and/ or food textures / please list:

## Is sensitive to clothing tags, etc, please list:

## Does not like his/ her hair brushed

## Refuses to walk barefoot

## Has trouble falling asleep or staying asleep

## Gets "stuck" on a task/ toy and has difficulty changing to another task

## Is fearful of swings, slides, or other playground structures

## Is fearless on swings, slides, and all other playground equipment

Comments:

