Occupational Therapy – Child Intake History

CHILD'S NAME: _____ DATE: _____

AGE: _____ RELATIONSHIP TO CHILD: _____

Please describe the reason we are seeing you today:

_____
_____
_____

When did this start? _____ Gradual or Sudden (circle one)

Who can we thank for your referral? _____

Do you have any special needs/concerns of which we should be aware? (i.e., vision, hearing, speech, language assistance, physical limitations, sensitivity to smell, environmental concerns)

☐YES ☐ NO

Please describe how we can best assist you

_____
_____

Are you receiving therapy services anywhere else? (School, home, etc.)

MEDICAL HISTORY:

Is the child taking medications? (Generally)

_____
_____
_____

Does he/ she have any allergies? ☐YES ☐NO If yes, please list:

_____

_____

_____

Please list any past surgeries: (If applicable)

_____
_____

Any complications with pregnancy or birth?

_____
_____

Do he/ she have any problems with balance or falls or running into things? ☐ YES ☐ NO If yes, please describe:

_____

_____

SOCIAL HISTORY:

Is the child in school? _____ Where? _____

What type of play does child participate in? (Likes, Dislikes)

_____

_____

What is interaction with peers or siblings?

_____

_____

Is the child:

Dressing him/herself ☐ NO ☐YES _____

Crawling ☐ NO ☐YES _____

Potty Trained ☐NO ☐YES _____

Washing him/herself ☐NO ☐YES _____

Feeding him/herself ☐NO ☐YES _____

Using Utensils ☐NO ☐YES _____

Clapping ☐NO ☐YES _____

Following verbal directions ☐NO ☐YES _____

Following a routine ☐NO ☐YES _____

Easily excited or upset due to their environment ☐NO ☐YES _____

Show aversion to touch ☐NO☐YES _____

What are your concerns for this child?

_____

_____

_____

What is your goal for occupational therapy?

_____

_____

_____