Achievement Therapy Center, LLC

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Occupational Therapy Intake **Patient Name**_____

At what age did your child demonstrate the following? sitting up _____ crawling_____ standing_____ walking _____ finger feeding _____ eating with spoon _____ potty-trained _____ undressing self _____

Activities of Daily Living

Does your child dress him/herself Y N If not, how do they assist you?

Does your child feed him/herself Y N If not, how do they assist you?

Does your child eat neatly for his/her age? Y N

Does your child use utensils appropriately? Y N If not, please describe

Does your child brush his/her teeth? Y N If not, please describe

Does your child display sensitivity to clothing, food textures or sounds? Y N If yes, please describe and explain how you have accommodated this

Please circle if your child is able to complete the following independently?

Tie Shoes Button buttons Zipper Coat Snap pants or jackets
(Elaborate if necessary)

Where does your child typically eat, i.e. at the table, high chair, living room?
Additional comments: _____

Fine Motor Skills

Is your child able to write legibly/age appropriately? Y N If no, please describe difficulties

Does your child hold utensils too tightly or too loosely in his/her hands (circle one if it applies).

Does your child have a dominant hand? Right Left No

Additional comments: _____

_____

Gross Motor Skills & Body Awareness

Did your child spent much time in car seats while not in the car? Y N

Did your child enjoy baby swings as infant, the kind that plays music, etc. and sets inside house?

Did your child crawl? Y N On hand/knees or slide on belly? For how long before walking?

_____

Did your child walk before 10 months? Or start walking after 15 months?

Does your child bump into things? Y N Does he/she trip or fall a lot? Y N

Does he/she seem awkward or clumsy? Y N Are your child's movements slow and deliberate? Y N

Can your child skip? Y N Ride a bike? Y N Hop on One Foot? Y N

Does your child bump into objects and other people on purpose? Y N

Does your child slump when sitting? Y N

Does your child seem weak or strong? (circle one) Do your child's muscles feel firm, rigid, or soft? (circle one)

Additional comments:

_____

_____

Oral

Does your child avoid any foods?

Does your child seem overly sensitive to smells? Y N What types of foods does your child like?

_____

_____

Does your child have any feeding/swallowing problems? Y N If yes, please describe

_____

_____

_____

Additional comments:

_____

_____

_____

Visual

Does your child have any diagnosed visual problem? Y N If yes, describe

When was the last time your child had his/her vision assessed and by whom?

Has your child been evaluated for or received vision therapy? If yes, when/with whom?

Is your child able to close his/her eyes for short periods of time? Y N

Is your child distracted in a “busy” room? Y N

Does your child enjoy puzzles? Y N What type of puzzles can he/she complete successfully alone?

Does your child look at you and others when you are talking? Y N

Does your child appear not to notice things in their environment? Y N

Does your child like to look at books? Y N

Additional Comments:

_____

_____

_____

Behavior/Temperament

Please describe your child’s personality

_____

_____

How do you handle behavior problems or tantrums at your house?

_____

_____

Does your child have tantrums Y N How often? Is your child an early riser or slow to get going?

Does your child like a routine? Y N

Is he/she bothered by breaks in routine? Y N

Can your child play alone? Y N

Does your child play alone all of the time? Y N

Who does your child prefer to play with?

Does your child demonstrate self-stimulating behaviors? Y N

If yes, please describe

Please describe your child's daily routine:

_____

_____

_____

_____

What is your child's nighttime routine?

_____

_____

_____

Does your child sleep through the night? Y N

Does your child wake during the night? Y N

Does your child sleep in their own bed? Y N

Does your child have difficulty going to sleep? Y N

What is your favorite thing about your child?

What do you find frustrating about your child?

What are your child's favorite toys?

Where does he/she like to play?

Does your child have any favorite games or activities?

How is your child doing at school? What is your child's attitude towards school?

What would you like for your child to accomplish while receiving Occupational Therapy?

_____

_____

_____