Initial Occupational Therapy Intake Form

BOOST Kids
occupational therapy & yoga

Child's legal name: _____ Nickname: _____

Child's DOB: _____

Parent name(s): _____

Referring Physician: _____

Reason for OT evaluation: _____

Birth History:
Pregnancy and birth history/complications _____

Type of delivery: caesarian / vaginal / breech

Length of pregnancy _____ Corrected Age (if premature) _____

Medical History:
Current Medications _____

Allergies _____

Any previous surgeries _____

Illnesses/Hospitalizations _____

Formal Diagnoses _____

Specialist(s) seen _____

Current or previous therapies _____

Hearing exam: Y / N Date: _____ Outcome: _____

Vision exam: Y / N Date: _____ Outcome: _____

Social History:
Living with _____

Daycare/School _____ Grade _____

Current interests/strengths:
Favorite toys/games/activities _____

Strengths _____

Areas of Concern (check all that apply)

___ Fine motor skills
___ Attention and focus
___ Self-regulation
___ Sensory modulation/processing
___ Strength
___ Posture and balance
___ Visual motor and visual perceptual skills
___ Coloring, drawing, handwriting
___ Following multi-step commands
___ Self-care (dressing, grooming)
___ Coordination
___ Motor planning (executing new tasks)
___ Eating habits/behaviors (picky eating, refusing to try new foods)
___ Other: _____

Person providing information: Relation to child: Date: / /