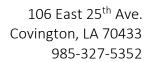


Individualized Needs Assessment (OT)

Child's name:	Date of Birth:
Name of person completing this form:	
Relationship to child:	
Is your child adopted? Yes No	
Birth History	
Did the mother have any complications	during pregnancy? Yes No
If yes, please describe	
Child was born: full-term prema	ture If premature, how many weeks?
Delivery: vaginal with forceps	C-section
Were there any complications?	
Was your child placed in the Newborn Ir	ntensive Care Unit? If so, how long?
Please describe any other medical probl	ems or complications at birth.
Developmental History	
Please indicate at what age your child a	chieved the following milestones. Mark N/A for those
which your child has not achieved yet.	
Rolled overSat al	one
CrawledPulled to	stand
Stood independently	Walked independently
BabbledSaid first	word
Drank from a cup	Used spoon
Toilet trained	
Dressed self	
Any current physical limitations: Yes	No

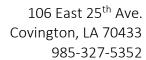




If yes, please describe
Comments:
Medical History
Current diagnosis:
Current physician(s). Please list all that child sees currently
Annual in the second se
Any previous hospitalizations: Yes No
If yes, please list
Any previous Surgeries: Yes No
If yes, please list
Previous psychological evaluation: Yes No
If yes, please describe or provide copy of evaluation.
Medications: Yes No
If yes, please list dosage and frequency
Allergies: Yes No
If yes, please list and list reactions
Does your child use any special equipment? Yes No
If yes, please describe
Any feeding concerns? Yes No
If yes, please describe



Does your child have a history of ear infections? Yes No		
Does your child have or had tubes placed in his/her ears? Yes No		
If yes, when?		
Any vision concerns? Yes No		
If yes, please describe		
Caregiver Concerns		
What are your main concerns with your child?		
What are your child's strengths?		
Has your child received occupational therapy, physical therapy, or speech therapy in the past or		
currently receives services? Yes No		
If yes, please indicate where, which services, and for how long:		
Educational Information		
School/Educational program currently attending:		
Current grade level:		
Does your child have an IEP? Yes No		
Please circle if your child receives any of the following:		
OT PT Speech Special Education Behavior Intervention		





If yes, please list frequency and duration of these services:
Other special service not listed
Please circle if your child's teacher have concerns with your child's development in any of the
following areas:
Motor skills Social abilities Self-help skills Learning abilities Comments:
Social/Emotional Development
Please describe your child's personality
Does your child interact well with others? Yes No
Does your child have any trouble making friends? Yes No
Does your child have difficulty calming himself/herself when upset? Yes No Comments
Comments
Thank you for taking the time to fill out this questionnaire. This information will help us to
become more familiar with your child and allows us to provide the best service possible to you
and your child.
Signature:Date:
Datient Name