



**Advanced Therapy & Nutrition, PLLC**  
**602-697-4454**

### **Occupational Therapy Intake Form**

Please complete the following form to the best of your ability, the more information you provide, the better we can understand and help your child. Thank you in advance!

Child's Name: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

Name of school: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Parent email: \_\_\_\_\_

Parent Phone: \_\_\_\_\_

Has your child had a vision and hearing test within the past year?

- YES.
- NO

Has your child received occupational therapy services in the past? Has your child had any occupational therapy evaluations within the past year? If so, with what provider, what assessments were administered, and when was this assessment completed with your child?

- YES. If Yes, please circle the settings that apply: School-based, Outpatient, or Both
- NO

1. What are the primary occupational therapy based concerns that you have for you child leading up to this evaluation?
  
2. When did you first notice a concern with your child's motor development or concerns with your child's sensory processing skills?
  
3. What strategies or techniques do you currently use that you find helpful with addressing the areas of concern?
  
4. What gain(s) has your child made over the past year that has made the most impact in his/her life?

5. What do you hope to see your child doing more independently or with greater ease one year from now?
6. What are your child's strengths and interests?

*The following check boxes will help guide the evaluation and treatment process. Please mark any of the boxes below that you feel describe your child. Marking the box indicates an area of difficulty or concern. Please describe any additional details/comments that you feel are relevant in each category below.*

### **Self-Care**

- increased assistance needed for dressing  unable to follow simple hygiene routine (5 years and up)  difficulty/delayed potty training  poor sleep habits (ie: trouble falling or staying asleep)  difficulty with utensil use / self-feeding  difficulty managing/organizing school-materials  Other: \_\_\_\_\_

### **Social Interaction**

- difficulty interacting socially and engaging with family and peers  difficulty making friends  difficulty adapting to new environments  delayed language skills  overly focused on one subject  difficulty coping in the school environment  Other: \_\_\_\_\_

### **Sensory Processing / Behavior**

- overly sensitive and responds negatively to loud sounds  avoids touch from others  difficulty/refusal with grooming (ie: hair brushing, bathing.)  avoids/refuses to wear certain clothing  limited safety awareness; high pain tolerance  constantly moving, jumping, crashing, rocking  enjoys hanging upside down (ie: over edge of couch)  doesn't respond to name being called  short attention span  easily distracted  impulsive  hyperactive  low energy  emotionally reactive, frequent meltdowns or temper tantrums  difficulty coping with change in routines  difficulty, increased time required, increased behaviors transitioning from preferred to non-preferred activities (ie: play to clean up, playground to home)  inability to calm self when upset  difficulty with multi-step tasks/directions  Other: \_\_\_\_\_

### **Movement and Body Awareness**

- appears clumsy or uncoordinated  difficulty going up and down stairs at an age appropriate time  difficulty with the concept of right and left  poor ball skills  tires easily; needs frequent rest breaks when playing  low muscle tone  high muscle tone  poor balance  fearful of feet leaving the ground  does not explore or enjoy playground equipment  difficulty coordinating both sides of the body  doesn't cross midline of his or her body during play and school tasks (if known)  avoids tasks and games that require increased motor skills/movement  Other: \_\_\_\_\_

### **Oral Motor/Oral Sensory**

- drools excessively  chews food in front of the mouth, rather than on the molars  difficulty using a cup at an age-appropriate time  difficulty drinking from a straw at an age-appropriate time  difficulty weaning from bottle or breastfeeding  appears to be excessively picky when eating, only eating certain types or textures of food  increased mouthing of toys or objects beyond an age-appropriate time

Other: \_\_\_\_\_

**Play Skills**

difficulty with imitative play  needs adult guidance to initiate play  wanders aimlessly without purposeful play  moves quickly from one activity to the next  participates in repetitive play for hours (ie: lining up toys)  does not join in with peers/siblings when playing  difficulty with concepts of sharing and turn taking

Other: \_\_\_\_\_

**Fine Motor Skills**

difficulty using feeding utensils at an age appropriate time  difficulty manipulating toys and puzzles  seems to avoid tasks/games that require fine motor skills  difficulty with pencil grasp  difficulty with coloring, drawing, tracing  poor handwriting, letter/number formation  not developing a hand dominance at an age appropriate time (by 5-6 years old)  difficulty using scissors  difficulty with clothing fasteners: zippers, buttons, shoelaces

Other: \_\_\_\_\_

**Visual Processing**

difficulty recognizing letters  makes letter/number reversals after the age of 7  difficulty copying shapes or letters  difficulty with spacing and sizes of letters  loses place when reading or copying from the board  difficulty finding objects among other objects  poor eye contact

Other: \_\_\_\_\_

**Office:**

- Fee schedule/agreement
- Consent on file
- Intake Form