DAVIES INSTITUTE
FOR SPEECH & HEARING

Occupational Therapy Intake Form

Child's Name: _____ **Child's Date of Birth:** _____

When was your child first diagnosed with the condition, injury, or developmental delay? Has there been any changes in the past 6 months in regard to the diagnosis (i.e. worsening or new development of symptoms)?

_____

_____

Does your child have any other difficulties or diagnoses that are influencing their development?

_____

_____

Has your child been seen or are they currently being seen by an occupational therapist or physical therapist? If yes, please explain.

_____

_____

Has your child been seen or are they currently being seen by any other specialists? If yes, please explain.

_____

_____

_____

Developmental History

Provide the approximate age at which your child began to do the following: (leave blank if not performed yet)

Hold Head Up	_____	Sit	_____	Roll Over	_____
Crawl	_____	Stand	_____	Walk	_____
Feed Self	_____	Dress Self	_____	Toilet Train	_____

Child's physical development has been:	**FAST**	**NORMAL**	**SLOW**
Child's coordination has been:	**GOOD**	**AVERAGE**	**CLUMSY**

Have there ever been any difficulties with feeding? If yes, please describe.

_____

_____

Have there ever been any difficulties with behavior or sensory processing? If yes, please describe.

_____

_____