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 **Occupational Therapy Initial Intake**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**General Information**

Client’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Languages spoken in home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Siblings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attend school or daycare:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PCP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Background Information**

Reason for referral to OT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Concerns regarding your child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Goals for your child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous therapy services received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History (please Check)**

* Prenatal complications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Complications during labor/delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Meds?\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_\_

Extra hospitalization required?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeding Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Problems in infancy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medical or developmental diagnosis?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Health Issues/significant illnesses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Take Medications? (please list and for what purpose)\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* History of seizures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Surgeries?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Respiratory problems/asthma \_\_\_\_\_\_Eczema
* Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_Food Intolerances
* Feeding Issues \_\_\_chewing \_\_\_swallowing \_\_\_\_\_GI issues
* Diagnosed Vision or Hearing delays?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other Medical Concerns or Precautions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Occupational Therapy Initial Intake**

**Developmental History (please Check)**

* Delayed Developmental Milestones \_\_\_motor \_\_\_feeding \_\_\_speech

**Activity Level (please check)**

* Active
* Typical
* Low arousal
* Difficulty sitting still
* Distracted
* Prefers sitting or sedentary activity

**Behavior/Play Skills (please check)**

* Seem hyperactive, always on the go
* Difficulty with changes in routine
* Rigid, set in his/her ways
* Underactive, difficult to engage in movement
* Calm, patient, relaxed
* Easy going, happy
* Cautious to try new things
* Aggressive when upset \_\_bites \_\_\_hits \_\_\_temper tantrums
* Self stimulatory or repetitive behaviors
* Frustration with expressing needs and wants
* Difficulty with social skills \_\_\_sharing \_\_\_\_\_making friends \_\_\_\_\_taking turns
* Difficulty with sleep patterns
* Shows decreased safety awareness

**Self help skills (please check)**

* Difficulty eating \_\_\_\_chewing \_\_\_\_swallowing \_\_\_\_drooling
* Limited tolerance of food textures/ types
* Gag or throw up when eating
* Difficulty sucking or drinking from a bottle, cup

\_\_\_\_Uses Bottle \_\_\_\_\_uses sippee cup \_\_\_\_\_open cup

* Unable to finger feed, use utensils well

\_\_\_\_finger feeds \_\_\_\_\_\_spoon feeds \_\_\_\_\_

* Aversion to brushing or cutting hair
* Aversion or poor tolerance of tooth brushing
* Difficulty with dressing/undressing

\_\_\_helps with dressing \_\_\_\_\_undresses \_\_\_\_\_dresses self

* Difficulty with fastens
* Slow toilet training skills \_\_\_\_toilet trained \_\_\_\_in progress \_\_\_\_not started

 **name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date**

 **Occupational Therapy Initial Intake**

**Sensory Processing (please check)**

**Tactile Processing**

* Dislikes touching various textures (sand, grass, messy food)
* Seeks or craves touch
* Dislikes being held or cuddled
* Distressed when fingers or face is messy or dirty
* Is not aware when dirty or when hurt
* Distressed with grooming activities (brushing teeth, hair etc. )
* Seeks oral stimulation or avoids oral textures, picky eater

**Auditory Processing**

* Distressed by loud or sudden sounds
* Frequently covers ears to avoid sounds
* Easily distracted or difficulty concentrating with background noise
* Difficulty understanding or listening
* Has a diagnosed hearing or auditory impairment

**Visual Processing**

* Wears glasses or has a diagnosed visual impairment
* Squints or covers eyes
* Difficulty concentrating with visual distractions
* Reduced eye contact
* Poor tracking or keeping eye on target
* Visual perception delays (puzzles, copy tasks)

**Muscle Tone**

* Weak muscle tone, fatigues easily
* Diagnosed muscle problem
* Flat feet or walks on toes
* Poor posture, slouches when sitting or on floor
* Poor core strength ie., crawling, wheelbarrow walk, climbing

**Movement/body awareness**

* Enjoys moving, swinging, slides
* Seeks spinning, hanging upside down
* Fearful of moving through space, slides, heights, stairs
* Likes rough housing, crashing, jumping
* Bumps into things, clumsy, accident prone
* Clumsy, falls easily, poor balance
* Difficulty learning new movements

**Coordination**

* Difficulty using both sides of body together ie., clapping patterns, pumping swing, jumping jacks
* Fine motor problems ie., grasp, pinch strength, manipulation of small items

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_

 **Occupational Therapy Initial Intake**

**Coordination**

* Gross motor delays ie., jumping, hopping, skipping, riding bike
* Poor writing skills
* Hand dominance not well established
* Confuses right and left
* Poor ball skills
* Difficulty playing on play ground, recess or sports

**Please list any other areas of concern you would like addressed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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