SHARKKS
Therapy

P: 623-444-8880
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OCCUPATIONAL THERAPY PEDIATRIC INTAKE FORM

DATE: _____
NAME: _____ DOB: _____ Age: _____
GENDER: MALE/FEMALE
ADDRESS: _____
PHONE NUMBER: _____
PATIENT RESIDES WITH: _____
NAME OF PARENT/GUARDIAN: _____
SIBLINGS: _____
PARENT'S EMAIL: _____
SUPPORT COORDINATOR: _____
PEDIATRICIAN: _____
CURRENT SCHOOL AND GRADE: _____
WHY ARE YOU SEEKING SERVICES: _____
LIST ANY SERVICES YOUR CHILD CURRENTLY OR PREVIOUSLY RECEIVED (OT, PT, SLP, ETC.): _____

MEDICAL DIAGNOSIS: _____

PATIENT HISTORY

MEDICAL HISTORY

Yes No Chicken Pox _____
Yes No Measles _____
Yes No Mumps _____
Yes No Scarlet Fever _____
Yes No Pneumonia _____
Yes No Rubella _____
Yes No Tonsillitis _____
Yes No Ear Infections _____
Yes No Strep Throat _____
Yes No Frequent colds _____

Describe any medical problems, illnesses, or accidents your child has experienced:
_____
_____

_____

_____

FAMILY MEDICAL HISTORY

Yes No High Blood Pressure _____
Yes No Diabetes _____
Yes No Lung Problem (Asthma) _____
Yes No Heart Problems _____
Yes No Miscarriages _____
Yes No Learning Disabilities _____
Yes No Nerve Problems _____
Yes No Mental Illness _____
Yes No Alcoholism _____
Yes No Drug Problems _____
Yes No Developmental Delays _____
Yes No Birth Defects _____
Yes No Other Significant _____

Full Term _____ Premature (# of weeks) _____ Birth Weight _____
Natural Delivery _____ Caesarean Section _____

Please not any complications during pregnancy or delivery: _____
_____
_____

Developmental Milestones (Age):

Rolled over:	Crawled:	Walked:
Toilet Trained:	Dressed Self:	Sat independently:

Medications: (Circle current medications)
Abilify
Adderall
Aripiprazole
Concerta
Dexedrine
Invega
Risperdal M-Tab
Risperdal
Risperidone M-Tab
Ritalin
Strattera
Wellbutrin

List other medications not listed above:
_____

ALLERGIES (Medications, foods, and environmental): _____

_____
_____

Please list your child's favorite play activities/toys: _____
_____
_____

Describe your child's communication skills: _____
_____
_____

How does your child get along with others (adults and children)? _____
_____
_____

Do you have any difficulties managing your child's behavior/attention span? _____
_____
_____

Does your child do anything that you feel may be unusual? _____
_____
_____

Describe mealtime routines or concerns: _____
_____
_____

Describe bedtime/sleeping concerns, if any: _____
_____
_____

Describe any daily routine/tasks that are difficult for your child: _____
_____
_____

Does your child experience frequent falls or injuries? _____
_____
_____

Do you feel your child has an unusually high or low pain tolerance? _____
_____
_____

Additional information that would be helpful to us in working with your child/family: _____
_____
_____
_____
_____