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OT Pediatric Evaluation Intake

Name: _____

DOB: _____ / _____ / _____

Reason for Referral: _____

What is your goal for your child's therapy visit? _____

Background Information & Medical History

Medical Diagnosis (if any): _____

Vision Test: _____ (circle normal/abnormal)

Hearing test: _____ (circle normal/abnormal)

Comments: _____

Does/Did your child experience any of the following: _____ Seizures _____ Surgery _____ Serious Injury

If yes to above, when, where & why: _____

Has your child received other evaluations, treatments, or specialty services (speech, physical therapy, cardiology, neurology, etc.)? _____

If yes, when, where & why: _____

Did you have any infections/illness/unusual stress during pregnancy (explain)? _____

Please check the following which occurred:

Vaginal Birth: _____ C-section: _____ Full term: _____ Premature: _____ How many weeks? _____

Other birth information: _____

Developmental History: At what age did your child do the following:

Rolled: _____ Sat Alone: _____ Crawled: _____ Walked: _____ Talked: _____ Potty Trained: _____

Comments: _____

Has your child been evaluated for an IEP: _____ Did they qualify for an IEP: _____

Thank you for the opportunity to work with you and your child!