|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name: | DOB: | Date: |  |
|  |  |  |  |

|  |
| --- |
| Please describe the major concerns you have for your child and why you are seeking occupational therapy services. |

**Developmental/Medical Histor**y

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| --- |
| Please describe any pertinent neonatal, birth or medical conditions? (Including allergies or special diet). |

**School History**

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| --- |
| What school does your child attend? |
| What is your child’s current grade? |
| Is your child in any special programs at school? (please describe). |
| Is your child experiencing any difficulty in school? (please describe) |

|  |
| --- |
| Please describe the other services your child is currently receiving. Please include the names of service providers. |

**Gross Motor Skills**

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| --- |
| Please describe your child’s general level of gross motor coordination. Can your child walk, run, ride a bike, throw and catch a ball? Include types of motor experiences your child enjoys and how much assistance or supervision your child needs. |

**Fine Motor Skills**

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| --- |
| Please describe how your child handles utensils such as a spoon, crayon, scissors etc. What type of grasp does your child use to hold utensils? |

**Dressing Skills**

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| --- |
| Does your child need assistance with dressing or dress independently?  Can your child manage buttons, snaps, zippers and shoe tying? |

**Mealtime**

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| --- |
| Please describe a typical mealtime with your child. Include what and how your child eats, appetite and behavior during meals. Does your child have strong food preferences/aversions? |

**Hygiene**

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| --- |
| Please describe your child’s behavior and level of independence for teeth brushing, washing hands and face, bathing and toileting. Does your child have difficulty with hair brushing and nail cutting? |

**Social Emotional Development**

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| --- |
| Please describe how your child interacts with family members and peers. |

**Speech-Language Skills**

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| --- |
| How does your child communicate? Does your child use any communication devices? Does your child use gestures and other methods of non-verbal communication? |

**Response to Sensory Input**

**Tactile**

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| --- |
| Does your child have any sensitivity to textures, fabric, socks or shoes? Is there a need to touch people and objects more than expected? Does your child dislike being touched by others? Does your child respond normally to pain? |

**Vestibular**

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| --- |
| Does your child seek out movement? Is your child cautious or fearful of  movement activities? What kind of movement does your child like or dislike? Is your child fearful when moved off balance? |

**Proprioceptive (muscle and joint awareness)**

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| --- |
| Does your child seem floppy or have low muscle tone? Does your child bump into objects or seem to have difficulty with body awareness? Does your child hold objects either too tight or too loose? |

**Auditory**

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| --- |
| Please describe your child’s sensitivity to sound. Include any types of sounds your child finds unpleasant. Is your child able to filter out irrelevant sounds? |

**Visual**

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| --- |
| Is your child sensitive to visual stimuli or busy environments? Does your child over focus on visual stimuli or is easily distracted by visual stimuli? Is your child comfortable with eye contact? |

**Please describe the following about your child:**

Temperament/General State of Arousal

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| --- |
| For example, how does your child cope with everyday stimuli. Are there signs of being over-responsive or under-responsive to sensory input? How much time do you spend comforting and nurturing your child? |

|  |
| --- |
| Does your child need a consistent routine or have difficulty with transitions? |

**Sleep Schedule**

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| --- |
| Does your child have trouble getting to sleep or sleeping through the night? |

**Attention Span**

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| --- |
| Is it appropriate for age? |

**Organizational Skills**

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| --- |
| Is your child able to keep track of personal belongings (homework, bedroom, toys) appropriately for age level? |

|  |
| --- |
| What do you see as your child’s strengths? |

|  |
| --- |
| What do you hope will be gained in occupational therapy and what goals do you have for your child? |

|  |
| --- |
| What days and times are you available for therapy? Please note that there is usually a wait list for the limited after school times |

Additional Information You Want to Share

Thank you very much in advance for your time completing this intake form.

Marla Cox MS, OTR/L

Eastside Pediatric Therapy Services

425-269-8933