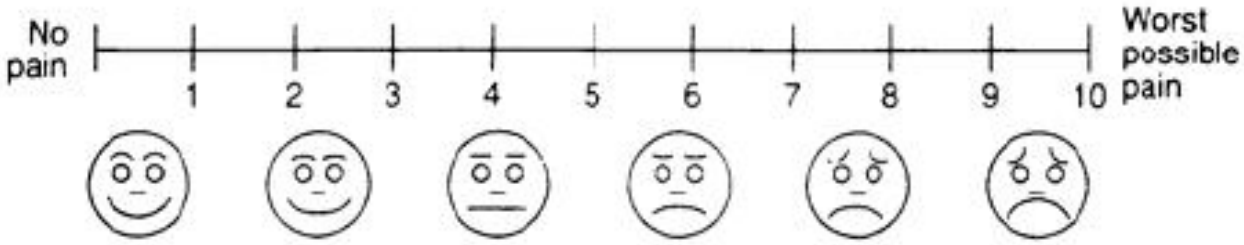
OCCUPATIONAL THERAPY / SENSORY
Intake Questionnaire

Person Completing Questionnaire:	**Relationship to Child:**		
Child's Name: (First) (MI) (Last)			
Date of Birth:	**Age:**		
Male **Female**			
Address: (Street) (Apt)	City	State	Zip Code
Phone Number:			

Diagnosis:	
Allergies (Drug and food)**:**	**Medications** (Prescription and non-prescription)**:**

Referring Provider:



What are your primary concerns/Why did you bring your child in for an evaluation?
When did you first become concerned about these behaviors?

Tell Us About Your Child:

What does your child enjoy (favorite things to play, do, participate in)?
What are your child's strengths (things they do well or feel successful with)?
What about your child do you especially enjoy?

Family History:	
Caregiver #1 Name: **Age:**	**Caregiver #2 Name:** **Age:**
Relationship to Child:	**Relationship to Child:**
Caregiver preferred method of learning: Listening Reading Pictures Demonstration Other:_____	**Caregiver preferred method of learning:** Listening Reading Pictures Demonstration Other:_____
Biological Adopted Step-child Foster Other:_____	Biological Adopted Step-child Foster Other:_____
*** Language(s) Spoken in the Home:**	**Primary Language of Caregiver:**

Persons currently living in home environment(s):

Name_____Relationship_____Age_____

Name_____Relationship_____Age_____

Name_____Relationship_____Age_____

Name_____Relationship_____Age_____

Name_____Relationship_____Age_____

Name_____Relationship_____Age_____

Is there any family history of developmental, motor, social, or language delays or diagnoses? (If yes, please explain.)

CONTACT INFORMATION:
The following are the best contact numbers for me to most reliably be reached during business hours:

_____ _____
(Phone #1) (Phone #2)

EMERGENCY CONTACT: In case of an emergency, I hereby authorize only the following persons to pick up my child:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Health Care Providers	
Primary Care Physician:	
Clinic Name:	**Clinic Phone Number:**

Birth History:	
Full Term **Prematurity at _____ weeks gestation**	
Single **Twin** **Triplet** **Other_____**	
Birth Weight:	**Birth Length:**
APGAR Scores: **1 min:_____** **5 min:_____** **10 min:_____**	
Maternal Health During Pregnancy: (check all that apply)	
No medical complications	Gestational diabetes
Hypertension	Bed rest
Drug/alcohol exposure	Medications:_____
Other:_____	
Labor: (check all that apply)	
Spontaneous without complications	Induced
C-section	Forceps and/or suction used
Other:_____	

Health of Infant at Birth: (check all that apply)	
No issues	Breathing difficulty
Jaundice	Brain bleed
Cardiac issues	Seizures
Gastroschisis	NAS-neonatal abstinence syndrome
Other:_____	Polyhydramnios

Health During Infancy: (check all that apply)	
Relatively healthy	Respiratory infections
Reflux	Recurrent ear infections
Feeding difficulties	Inconsolable, frequent crying
Hernia	Other:_____

Current Overall Medical Health: (please explain).	
Good Fair Poor	
Hearing: Any concerns with child's hearing? Yes No **Explain:**	
History of ear infections? Yes No	Date and results of most recent hearing screen:
Vision: Any concerns with child's vision? Yes No **Explain:**	Date and results of most recent vision screen:

Has your child ever had problems with (check all that apply):	**Explain**	**Onset Date**
Allergies		
Heart		
Kidney/Urinary		
Respiratory		
Liver		
Cranial Bleed		
Hydrocephalus		
Shunt		
Seizures		
Skin Reactions		
Memory/Cognition		
Pneumonia		
Dietary Restrictions		
Reflux		
Weight Loss/Gains		
Intrauterine drug exposure		
Other_____		

Diagnostic Tests: (MRI, EEG,CUS, X-ray, etc.)

Test	Date	Results

Specialists: (check all that apply)	**Name of Specialist(s)**	**Phone Number**	**Date(s) of Service**
Neurologist			
Psychologist/psychiatrist			
Orthopedist			
ENT (Ear, Nose, and Throat)			
Allergist			
Optometrist/ophthalmologist			
Gastroenterologist			
Cardiologist			
Nutritionist			
Endocrinologist			
Other:_____			

History of Surgeries, Major Injuries, Illnesses, and Hospitalizations:
Date/Reason:
Date/Reason:
Date/Reason:
Date/Reason:
Date/Reason:

Has your child ever been tested for or received a diagnosis of (check all that apply):	**Explain**	**Onset Date**

Autism		
Asperger's		
PDD-NOS		
Nonverbal Learning Disorder		
ADHD/ADD		
Seizure Disorder		
Sensory Processing Disorder		
Behavioral/Psychological		
Other _____		

Current and Previous Therapies: (OT/PT/SLP etc.)
Has your child ever received Occupational Therapy services? (If yes, from whom, where, and dates of service).
Has your child ever received Speech Therapy services? (If yes, from whom, where, and dates of service).
Has your child ever received Physical Therapy services? (If yes, from whom, where, and dates of service).
Has your child ever received Psychology, Social Work, or Behavioral support services? (If yes, from whom, where, and dates of service).

Motor Milestones: (please indicate **AGE** at which child reached milestone)
Rolled:
Sat:
Crawled:
Stood:
Walked:

Fine Motor Skills: (please check yes or no for each statement)		
My child is able to reach for toys.	Yes	No
My child is able to bang toys together in play.	Yes	No
My child is able to pick up small items (i.e. Cheerios).	Yes	No
My child is able to scribble.	Yes	No
My child is able to write his/her name.	Yes	No
My child is able to snip with scissors.	Yes	No
My child is able to draw a stick figure of a person.	Yes	No

Self-Care Skills: (please check yes or no for each statement)		
My child is able to *undress* him/herself independently.	Yes	No
My child is able to *dress* him/herself independently.	Yes	No
My child is able to feed him/herself independently using a fork.	Yes	No
My child is able to drink from an open-cup or from a straw.	Yes	No
My child is able to bathe him/herself independently with only verbal reminders.	Yes	No
My child is toilet trained. Age potty trained_____	Yes	No

Sleep: (please check yes or no for each statement)		
My child sleeps independently in his/her own bed/crib.	Yes	No
My child is able to easily fall asleep at night and for naps.	Yes	No
My child is able to sleep through the night without waking.	Yes	No # of times wakes _____
My child snores and/or has a history of sleep apnea.	Yes	No

Feeding: (please check yes or no for each statement)		
My child consumes liquids via breast/bottle.	Yes	No
My child receives nutrition via feeding tube.	Yes	No
My child coughs/chokes/gags when eating.	Yes	No
My child easily transitioned to solid foods.	Yes	No
My child appears to chew his/her food thoroughly.	Yes	No

Understanding Language:
When you talk to your child, how much does he or she understand? **Check one**:

A few words	Simple directions
Many words and phrases	Almost everything I say

Additional comments/examples:

Communicating 1:
How does your child let you know what he or she wants? **Check ALL that apply**:

Cries	Uses a few words
Points to what he or she wants	Says many words, but only one at a time
Uses gestures	Says two or three word sentences
Makes a few sounds	Uses long sentences
Makes many different sounds	

Additional comments/examples:

Communicating 2: (please check yes or no for each statement)		
My child answers when I talk to him or her.	Yes	No
My child talks about what he or she is doing.	Yes	No
Family members can understand my child's speech.	Yes	No
People outside of the family can understand my child's speech.	Yes	No

School/Academic Information:
School currently attending:
Grade:

Does your child currently receive any of the following services:(check all that apply)

Special Education Special Testing Accommodations

Resource Room

In school therapy (speech, occupational, or physical)

Has your child been evaluated for school based therapy services:

Yes **Date of evaluation(s):_____** No

***IF YES, PLEASE BRING A COPY WITH YOU TO THE EVALUATION.**

Does your child have an IEP/IFSP or 504 plan?

Yes No

***IF YES, PLEASE BRING A COPY WITH YOU TO THE EVALUATION.**

Does your child enjoy school?

Yes No

Please explain:

What areas of school are challenging for your child? (social interactions, attention, academic, handwriting, certain classes or times of day, etc.)

What, if any, concerns have the teacher(s) raised?

Please use the table below to write down your child's "typical" daily routine for weekday and weekend days.
***Be as SPECIFIC as possible. If additional room is needed, please feel free to continue on separate sheet or on back of paper.**

	WEEKDAY			**WEEKEND**		
	Activities	Primary Caregiver (s)	Setting	Activities	Primary Caregiver (s)	Setting
Early Morning						
Morning						
Midday						
Afternoon						
Evening						
Bedtime/Sleep routine						

Based upon the activities/situations/transitions/times of day, what **3** areas are the **most challenging**?

1.

2.

3.

Please complete the following chart based upon the above identified **3 challenges.**

CHALLENGE #1
Please explain, in detail, what occurs during this challenge. (What happens before? During? After?)
What makes this time/event challenging?
What would this time/event **IDEALLY** look like?

What things would need to change for this event to occur **IDEALLY?** What tools/strategies do you need to help make this happen?

CHALLENGE #2
Please explain, in detail, what occurs during this challenge. (What happens before? During? After?)
What makes this time/event challenging?
What would this time/event **IDEALLY** look like?

What things would need to change for this event to occur **IDEALLY?** What tools/strategies do you need to help make this happen?

CHALLENGE #3
Please explain, in detail, what occurs during this challenge. (What happens before? During? After?)
What makes this time/event challenging?
What would this time/event **IDEALLY** look like?

What things would need to change for this event to occur **IDEALLY?** What tools/strategies do you need to help make this happen?

Information I need in order to help my child:
I would like to have more information about… **Check ALL that apply**:

- Child development
- Diagnoses and treatment
- Laws governing services for children
- Early intervention services (birth-3 years)
- Financial assistance (e.g. insurance, SSI, Medicaid)
- Other: _____
- Family support groups
- Respite care
- Other treatment options
- Special education services

I acknowledge that I have received a copy of the *Welcome to Pediatric Therapy Services* orientation packet.

Caregiver Signature:_____ Date:_____