Schie SPEECH

Occupational Therapy Intake Form

Pediatrics

Patient Name: _____ **DOB:** _____

What are your goals for therapy?

_____

_____

Developmental History

Motor Skills (Check all that apply)

- ☐ Holds head up
- ☐ Reaches for an object
- ☐ Needs help dressing
- ☐ Difficulty with stairs
- ☐ Rolls Over
- ☐ Sits unsupported
- ☐ Trips Easily
- ☐ Potty Trained
- ☐ Crawls
- ☐ Walks
- ☐ Clumsy
- ☐ Stands Alone
- ☐ Jumps (2ft)
- ☐ N/A

Milestones

At what age did the patient begin to:

Roll Over: _____

Walk: _____

Sit Independently: _____

Run: _____

Crawl: _____

Spoke first word: _____

Behaviors and Skills

Does the child engage in EYE CONTACT during communication?	☐ Yes	☐ Sometimes	☐ NO
When given a choice, does the child prefer to play ALONE or with others?	☐ Alone	☐ w/ Others	
Does the child AVOID being barefoot?	☐ Yes	☐ Sometimes	☐ No
Does the child tolerate having MESSY hands?	☐ Yes, Loves it!	☐ Sometimes	☐ No, complains until hands are cleaned.

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What are some of the patients FAVORITE toys/interests?

_____

_____

What does the patient do well? What is s/he good at?

_____

_____

<u>Self-Care Skills</u> (Check all that apply)

Can the child TAKE OFF the following?	☐ Socks	☐ Shoes	☐ Pants	☐ Shirt
Can the child PUT ON the following?	☐ Socks	☐ Shoes	☐ Pants	☐ Shirt
Can the child do the following?	☐ Urinate w/o assistance	☐ Wash Hands	☐ Brush Teeth	☐ Brush Hair
	☐ Bowel movements w/o assistance	☐ Bathe / Shower		

<u>Feeding Skills</u>

Child can self-feed using:	☐ Spoon	☐ Fork	☐ Knife	☐ Pincer Grasp	☐ N/A
Does your child have any food aversions? (e.g. taste, texture, temp., color, size, etc.)			☐ Yes	☐ NO	☐ N/A

If Yes, Please describe: _____

_____

What foods does your child avoid? _____

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Education History: (Check all that apply)

- ☐ Full Time Daycare
- ☐ Part Time Daycare
- ☐ Full Time Preschool
- ☐ Part Time Preschool
- ☐ Homeschool
- ☐ Private School
- ☐ Public School
- ☐ N/A

School Info (if applicable):

Name of School: _____

Address: _____

Grade currently in: _____ Grades repeated, if any: _____

Services presently offered or attending in school: _____

How would you describe his/her handwriting?

- ☐ Average
- ☐ Neat
- ☐ Sloppy
- ☐ N/A

Can your child use scissors?

- ☐ Yes
- ☐ No
- ☐ N/A

How are your child's attention skills? _____

_____

Are there any concerns about academic performance (e.g. reading, writing, subject areas)?

- ☐ Yes
- ☐ No
- ☐ N/A

If yes, please describe: _____

_____