BUCKEYE THERAPY SERVICES, LLC

Background Information and Occupational Intake Form

Child's Name _____

Birth Date _____ Age _____

Parent/Guardian name _____Phone _____
Address _____
Email _____

2nd Parent/Guardian name _____Phone _____
Address _____
Email _____

Reason for referral and goals for occupational therapy?

_____

_____

_____

_____

_____

Child's grade _____ Does your child have an IEP? yes / no

School _____

Other Therapies: ____ OT ____ PT _____ Speech _____Psychology

Diagnosis given by other health care professionals?_____

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_____

Precautions / Restrictions _____

_____

Allergies _____

Special Diet _____

Hospitalizations, date _____

Any difficulties during pregnancy or delivery _____ Yes _____ No

If yes, please specify _____

_____

_____

Length of pregnancy _____

Current medications and what they are for:

_____

_____

Visual Impairment_____ wears glasses ___ Yes ___ no

Hearing Impairment ___ Yes ___ No If yes, _____

Chronic ear infections ____ Yes _____ No _____ tubes placed

Language _____Typical _____Delayed _____Impaired _____Non-verbal

_____

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Developmental History

Please check all the developmental milestones achieved:

___ rolling ___ sitting alone ___ creeping on all 4s ___ pull to stand

walking _____ (age) first word _____(age)

combined words _____ (age)

Developmental milestones were met ____ within typical ages _____ delayed

Self Care:	Independent	I assist 50% or more	Dependent (total assistance needed)
Take off pants			
Put on pants			
Takes off shirt			
Puts on shirt			
Buttons			
Zipper			
Snaps			
Puts on shoes			
Ties shoes			
Puts on socks			
Takes off socks			
Toileting			
Bathing routine			
Tooth brushing			
Scooping with a spoon			
Spears with a fork			

Drinks from open cup			
Drinks from straw			

Social and Occupational History

Does your child	Often	Sometimes	Never
Socialize with family and friends			
Communicates needs and wants effectively			
Hard to make friends			
Tend to interact/ play with younger children			
Enjoy time alone			
Tolerate change in routine			
Anxious, worries			
Has a sense of humor			
Easily frustrated			

Sensory Status

Does/Is Your Child	Often	Sometimes	Never
Overly sensitive to touch, noise, smells, etc			
Sensitive to light, fluorescent or sunlight			
Easily distracted, difficulty staying focused			

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Cont.	Often	Sometimes	Never
Easily overwelmed at playground or outings			
Slow to perform tasks			
Is restless or fidgety			
Clumsy, stumbles often, slouches in chair			
Crave rough housing			
Slow to perform tasks			
Have difficulty performing or avoids fine motor tasks			
In constant motion			
Difficult to calm once upset			
Gets stuck on tasks and has difficulty changing to another activity			
Have difficulty with learning new motor tasks			
Prefers to be sedentary			
Confuses similar sounding words			
Has difficulty following directions			
Afraid of heights or afraid of movement such as swings			
Stumbles over words, speech lacks fluency			
Has difficulty reading or reading aloud			
Frequently complains of head or stomach aches			

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Describe your child at present (ie. mostly quiet, very social, bossy, irritable, easy to please, argumentative, moody, funny, talkative, helpful, fearful, people pleaser, etc.)

_____

_____

_____

_____

_____

Child's strengths: _____

_____

_____

_____

Child's interests _____

_____

_____

Please provide any additional information that will help us better understand your child_____

_____

_____

_____

Thank you!
Leah Hall, MS, OTR/L
Licensed Occupational Therapist