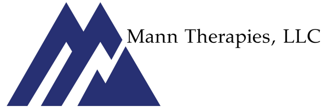
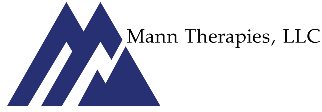


Occupational Therapy Intake Form			
Child's Name:		Nickname:	Age:
Family's Names:	Mom: Dad: Siblings:		
Patient contact info: email and phone	Phone:		
	Email:		
	Address:		

Date of Birth:	
City:	
County:	
State:	

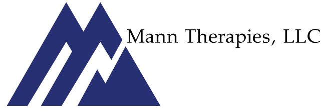
Child Information	
Age child started walking:	
Does the child wear orthotics? If yes, please describe	

Prior and Current Physical Therapy Services	
Early Intervention:	
NAME OF SCHOOL:	
GRADE:	
TEACHER'S NAME:	
DOES CHILD HAVE AN IEP OR 504 PLAN:	



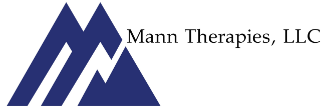
LIST THERAPIES PROVIDED AT SCHOOL:	
Any KNOWN CONCERNS AT SCHOOL:	
Community Resources/Current Programs **LIST THERAPIES PROVIDED OUTSIDE OF SCHOOL:**	

What are your child's strengths and interests?
What are your primary concerns from an OT perspective?
What are your 3 main goals for today's occupational therapy assessment?
1.
2.
3.



What 3 concerns to do you have regarding your child's movement?
1.
2.
3.

Pregnancy and Birth History	
LENGTH OF PREGNANCY:	
BIRTH WEIGHT AND LENGTH:	
CONCERNS DURING PREGNANCY OR LABOR:	
CONCERNS AS A BABY OR YOUNG CHILD:	
CURRENT MEDICATIONS:	
FOOD OR MEDICATION ALLERGIES:	
SPECIAL DIET:	



Medical History	
CURRENT MEDICAL DIAGNOSIS:	
LIST ANY HOSPITALIZATIONS AND LENGTH OF STAY:	
LIST ANY SURGERIES:	

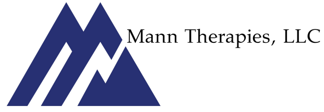
DEVELOPMENTAL HISTORY

PLEASE CIRCLE ALL DEVELOPMENTAL MILESTONES THAT YOUR CHILD HAS MET:

ROLL	SIT ALONE	WALK	FIRST WORD	COMBINED WORDS
PULL TO STAND	CRAWL	FEED SELF W/HANDS	EAT WITH A SPOON	EAT WITH A FORK
CUT FOODS	CUT WITH SCISSORS	RUN	JUMP WITH TWO FEET	HOP ON ONE FOOT
RIDE BIKE	CLIMB PLAY EQUIPMENT	PLAY INDEPENDENTLY	TOILET TRAINED	

OVERALL, WERE MILESTONES MET (CIRCLE ONE): TYPICAL RANGE DELAYED

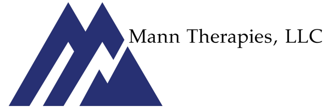
COMMENTS RELATED TO DEVELOPMENT:	



SELF HELP SKILLS

PLEASE CHECK THE AMOUNT OF ASSISTANCE YOUR CHILD NEEDS TO COMPLETE THE FOLLOWING:

	INDEPENDENT	I ASSIST 50% OR MORE	DEPENDENT
TAKES OFF PANTS			
PUTS ON PANTS			
TAKES OFF SHIRT			
PUTS ON SHIRT			
BUTTONS			
ZIPPERS			
SNAPS			
PUTS ON SHOES			
TAKES OF SHOES			
PUTS ON SOCKS			
TAKES OFF SOCKS			
TIES SHOES			
TOILETING			
BATHING ROUTINE			
TOOTHBRUSHING			
USING SPOON			
USING FORK			
DRINKS FROM OPEN CUP			
DRINKS FROM STRAW			
GETTING TO SLEEP			
STAYING ASLEEP			
CALMING/SOOTHING SELF			



SOCIAL AND OCCUPATIONAL INFORMATION

PLEASE CIRCLE ANY OF THE DESCRIPTIONS BELOW THAT APPLY TO THE CHILD CURRENTLY:

USUALLY HAPPY	EASY GOING	STUBBORN	RESISTANT TO CHANGE
FLEXIBLE	FIGHTS FREQUENTLY	EXCESSIVE TANTRUMS	NERVOUS TICKS/HABITS
WETS BED	FRUSTRATED EASILY	UNUSUAL FEARS	ANXIOUS
ACTIVE	SLUGGISH	HAS FRIENDS	DIFFICULTY MAKING FRIENDS
ENJOYS BEING SOCIAL WITH OTHERS			

PLEASE DESCRIBE ANY BEHAVIOR OR SOCIAL CONCERNS:	
PLEASE DESCRIBE ANY MOTOR COORDINATION CONCERNS:	
PLEASE DESCRIBE ANY KNOW SENSORY PROCESSING CONCERNS:	
PLEASE DESCRIBE ANY SPEECH OR LANGUAGE CONCERNS:	
WHAT STRATEGIES DOES CHILD USE TO CALM HIMSELF/HERSELF WHEN UPSET:	

Mann Therapies, LLC