



OCCUPATIONAL THERAPY INTAKE / DEVELOPMENTAL HISTORY

Thank you for your time to complete this form. It is lengthy, but is an important part of designing an individualized OT program for your child. This information provides the Occupational Therapist with complete and detailed information about your child and your concerns.

Child's Name: _____ Birth Date: _____
Form Completed By: _____
Address: _____ Home Phone: _____

Child's Handedness: Right Left Ambidextrous No Preference Not yet developed

Parents are: Married Separated Divorced Widowed Single Other

Child lives with _____ (include relationship)

Is child adopted or in foster care? _____

Parent/ Guardian Name: _____ Cell Phone: _____
Email: _____
Occupation: _____

Parent/ Guardian Name: _____ Cell Phone: _____
Occupation: _____
Email: _____

Names and Ages of Brothers and Sisters: _____
Emergency Contact: _____

Referred By: _____
Address: _____ Phone: _____

Pediatrician: _____
Address: _____ Phone: _____

Medical Diagnosis: _____

Current Medications/ Supplements: _____

Current Precautions or Allergies: _____

Results of Hearing or Vision Tests: _____

Other Pertinent Medical Information: _____

School: _____ Grade: _____

Teacher: _____ Classroom Type: _____

Child has IEP ? Yes No

Date of IEP Annual Review: _____

Date of 3 - year Reevaluation: _____

List Special Education Services and Service Providers:

Your perspective on current issues or concerns related to home

Your perspective on current issues or concerns related to school:

Your perspective on current issues or concerns related to peers/ extra-curricular activities:

Please list any therapies or services your child receives outside of school and providers:

PRIMARY CONCERNS:

What do you hope to gain from OT evaluation & treatment?

What are your child's gifts and strengths?

What concerns you most about your child?

Are there any problems with daily routines?

What particular skills would you like your child to gain in the next 6 months?

Is this your first evaluation for this concern? _____
If not, please list other evaluations and general results (agency, date, outcome):

PRENATAL / BIRTH HISTORY:

Was the pregnancy full term? Yes No If no, gestational age at delivery: _____

Weight at birth: _____

Any unusual illnesses during pregnancy? Yes No

If yes, please list: _____

Was labor induced? Yes No

Was birth by C-Section? Yes No

Were forceps used during delivery? Yes No

Complications during delivery: _____

Birth Injuries: _____

INFANCY AND EARLY CHILDHOOD:

Please describe any feeding problems:

Please describe any sleeping problems:

Did your child experience colic? Yes No

Did your baby dislike lying on stomach? Yes No

Did your baby dislike lying on back? Yes No

Did your baby become calmed by car rides or infant swings? Yes No

Did your baby become upset by car rides or infant swings? Yes No

DEVELOPMENTAL MILESTONES (please list age if remembered):

Roll Over _____

Sit alone _____

Crawling _____

Walking _____

Chew solid food _____

Drink from a cup _____

Say words _____

Say sentences _____

CURRENT MOTOR PERFORMANCE: A = Always S = Sometimes NY = Not yet

	A	S	N Y	COMMENTS
Picks up small objects				
Points to an object				
Uses writing utensils				
Feeds self with utensils				
Brushes teeth independently				
Dresses him / herself				
Ties shoes independently				
Wipes self after toileting				
Jumps with 2 feet together				
Skips with both feet				
Swims w/ crawl or other strokes				
Pumps self on swing				
Kicks a ball				
Catches a ball				
Turns pages of a book				
Rides tricycle/training wheels				
Rides a bicycle				
Blows a whistle				
Cuts with scissors				
Colors inside lines				
Cuts food with a knife				

COMMUNICATION SKILLS: A = Always S = Sometimes NY = Not Yet

	A	S	NY	COMMENTS
Speech understood by stranger				
Communicates with gestures				
Communicate with vocalization				
Communicate with single words				
Communicates with phrases				
Communicates with sentences				
Expresses self with sign language/ Picture Symbols				
Complex communication				
Understands familiar utterances				
Understands complex utterance				
Understands story w/out picture				
Understands multistep directions				

BEHAVIOR

Issues at home:

Issues in school:

Management Strategies:

LIKES AND DISLIKES

Things your child seeks out or finds reinforcing (characters, people, shows, songs, toys, books) :

Things your child fears, finds irritating, avoids, or resists:

SOCIALIZATION

Please check all that apply to your child's social behavior:

- shy
- friendly
- very active
- inactive
- demands attention
- withdrawn
- anxious
- craves routine
- poor self-confidence
- frequent tantrums
- trouble separating from parents
- sad or depressed

Other personality traits and characteristics:

Describe how your child interacts with adults, siblings, and peers:

Scale for following tables:

A = Always, O = Often, S = Sometimes, R = Rarely, N = Never

	A	O	S	R	N	COMMENTS
VISUAL PROCESSING						
Distracted by visual stimulation						
Dislikes eyes covered						
Likes playing in the dark						
Irritated by bright lights						
Trouble following object w/eyes						
Avoids eye contact						
AUDITORY PROCESSING						
Dislikes music or singing						
Has difficulty with rhythms						
Seems sensitive to sounds						
Distracted by noise						
MOVEMENT PROCESSING						
Enjoys swings						
Has good balance						
Enjoys merry go rounds / rides						
Likes being tipped upside down						
Hesitates on climbing equipment						
Hesitates on stairs						
Dislikes elevators / escalators						
Walks on toes						
Jumps on beds & other surfaces						
Bangs head						

	A	O	S	R	N	COMMENTS
Does not alternate feet on stairs						
Spins self around						
Upsets if head tips backwards						
TASTE AND SMELL						
Deliberately smells objects						
Reacts defensively to odors						
Reacts defensively to tastes						
Has trouble eating food w/lumps						
Puts non-food items in mouth						
No response with strong flavors						
TOUCH						
Seems excessively ticklish						
Irritated by tags in shirts						
Dislikes haircuts or shampooing						
Complains of seams in socks						
Discomfort with clothing texture						
Over or under-dress for weather						
Prefers to initiate touch						
Dislikes unexpected touch						
Craves to be held or cuddled						
Overly sensitive to pain						
Underly sensitive to pain						
Constantly touching objects						
Dislikes bathing or showers						

	A	O	S	R	N	COMMENTS
Can't tolerate water on face						
Pinches, bits, or hurts self						
Avoids messy play						
Dislikes nail cutting						
Tends to bump or push others						
MOTOR SKILLS						
Bumps into things frequently						
Trouble sequencing steps						
Awkward pencil grip						
Poor handwriting						
Weak hands						
Breaks objects frequently						
Drops things easily						
Tires with physical activity						
Deliberately falls or tumbles						
Sloppy eating habits						
Slow to complete motor tasks						
Slow to learn motor tasks						
Reluctant to play sports						
Can't sit still in chair						
Slumps while sitting						
Has flat feet						
Trouble with eating utensils						
Frequently spills liquids						

	A	O	S	R	N	COMMENTS
Tends to be a slow dresser						
Puts clothing on backwards						

BOWEL AND BLADDER CONTROL

Is your child toilet trained? Yes No

If no, please answer the following:

Continue to have accidents during the day until age _____

Continue to have accidents at night until age _____

Has difficulty identifying the need to eliminate? Yes No

Does your child show any interest in toilet training? Yes No

Please list any concerns or goals in this area:

SLEEP PATTERNS

Does your child have regular sleep patterns? Yes No

Does your child settle to sleep easily at night? Yes No

Does your child have trouble staying asleep? Yes No

Does your child sleep in his or her own bed? Yes No

Is your child an early riser, and immediately on the go? Yes No

Is your child slow to wake in the morning? Yes No

What time does your child go to bed? _____

What time does your child wake up on weekdays? _____ on weekends? _____

Please list any concerns or goals in this area:

Please include any other information you would like us to know about your child, which is not contained above. Attach an additional page, if necessary.

Please return this to information@bostonsensorysolutions.com by email or mail it to:
 Boston Sensory Solutions, LLC 500 Granite Ave, Suite 1, Milton, MA 02186.
 Please make a copy for yourself before placing original in the mail.