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 Windowed 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	NY	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	N Y	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.