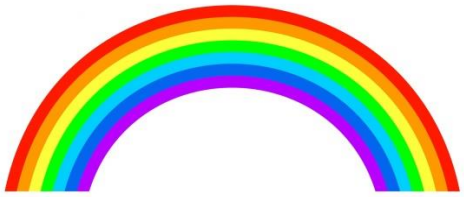

The Right Track Pediatric OT, LLC

Karen Nassan, MS OTR/L
Occupational Therapist
917-647-2309
righttrackot@gmail.com

Pediatric Occupational Therapy Intake Form

Today's Date:_____

Person completing this form:_____ Relationship to child:_____

DEMOGRAPHIC & FAMILY INFORMATION

Child's Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Male _____ Female _____

Parent's Name: Mother _____

Father _____

Address: _____

Telephone Number: _____ Cell: _____

Pediatrician: _____ Insurance: _____

Name and age of siblings:_____

_____

BIRTH/MEDICAL HISTORY

Was the child full-term? Yes____No____ If no, what was the gestational age?_____

Child's weight at birth:_____

Normal pregnancy and delivery: Yes____ No ____

If no, please describe: _____

_____

Describe any illnesses, accidents, injuries, and hospitalizations of the child (include child's age):_____

_____

_____

Is your child currently in good health? YES____ NO____

Is your child currently taking any medication? YES____ NO____ If yes, please list:_____

_____

Does your child have a formal medical diagnosis? Yes____ No____ If yes, please list:_____

_____

Does your child have any food allergies?_____

Has the child been evaluated for, or treated in the past for OT, PT or Speech services? Yes____No_____

If yes, please explain:_____

_____

_____

Have any siblings ever received PT, OT, or Speech Therapy? Yes ___ No____

If yes, please explain: _____

_____

Do any family members have learning or physical development problems? Yes ___ No____

If yes, please explain: _____

AREAS OF CONCERN/GOALS

What is your primary concern today? _____

_____

When did you first have concerns about your child? _____

_____

What strategies or techniques have you been trying independently? _____

_____

What specific skills would you like your child to achieve in therapy? _____

_____

MOTOR DEVELOPMENT

List approximate age at which your child demonstrated the following skills:

Crawled: _____ Sat up: _____

Started to walk: _____ Walked unassisted: _____

How often was your infant placed on their belly?_____

Any concerns regarding fine motor skills (i.e., stacking blocks, drawing, cutting, writing)? Yes ___No____

If yes, please explain: _____

_____

SOCIAL/EDUCATIONAL

Child's School:_____ Grade/Level: _____

If not school age, other group experience? _____

How does your child play? _____

_____

Is your child able to pay attention as well as most other children his/her age? Yes ____ No ____

SELF-HELP SKILLS

Any concerns regarding feeding and eating skills (i.e., using spoon/fork, drinking through straw, food choices, ability to chew/swallow)? Yes ___ No ____

If yes, please explain:_____
_____

Any concerns about food choices (i.e., eats only certain foods or textures)? Yes ____No_____

If yes, please explain: _____

Any concerns regarding dressing skills (i.e., getting dressed/undressed, managing buttons/snaps/zippers, shoe tying)? Yes ____ No ____

If yes, please explain:_____

Any concerns regarding hygiene skills (i.e. tooth brushing, bathing, combing hair)? Yes ____ No ____

If yes, explain _____

SENSORY MOTOR SKILLS

Please check any statements that describe your child

_____ Is overly sensitive to touch, noise, smells, etc

_____ Avoids touching certain textures (please list: _____)

_____ Avoids messy play (i.e., finger paints, playdough, mud, sand)

_____ Unaware of that face or hands are dirty (i.e., nose running, food on face)

_____ Is sensitive to clothing tags or textures

_____ Only eats certain foods or food textures (please list:_____)

_____ Refuses to walk barefoot

_____ Frequently bumps into furniture, walls, or other people

_____ Unaware of being touched or bumped unless done with extreme force

_____ Seems unsure of how to move his/her body; is clumsy and awkward

_____ Slumps or slouches when sitting; places head on hand when sitting

_____ Frequently touches people and objects

_____ Frequently gets in everyone else's space

_____ Is in constant motion

_____ Has difficulty sitting still

_____ Has trouble falling asleep or staying asleep

_____ Is fearful on swings, slide, playground equipment

_____ Is fearless on playground equipment

Additional Comments:

_____

_____

_____