OCCUPATIONAL THERAPY INTAKE

Occupational Therapy promotes functional independence in people who are dealing with the effects of disease, injury, emotional or physical trauma, disability or developmental delays. It is important that general health information be given to the OT in order to understand more fully the cause of the difficulties that your child is facing. Please fill out the questions below to the best of your ability. You can choose to not answer certain questions. Remember that only pertinent information will be included in any reports.

Child's Name: _____

Date of birth:_____

Age:_____

Grade:_____

School:_____

Diagnosis: (if applicable)_____

_____

_____

Who provided diagnosis? _____

What age was diagnosis given? _____

Client/Parent concerns_____

_____

_____

Do you give consent to start assessment process? Y / N

Parents Names:_____

Phone number: _____

Address: _____

_____

_____

How did you hear about OT services?

_____

_____

What are the teacher concerns if any?

_____

_____

How are these problems/issues affecting their everyday life? ie. Because of these issues, my child can't do:

_____

_____

_____

_____

What do you need to see change so that you can say therapy worked?

_____

_____

_____

_____ _____

Occupational Therapist Date

I. PRENATAL HISTORY

	Yes	No
Pregnancy: 1. Were there any illnesses, injuries, fainting spells, bleeding anemia, operations or any other difficulties during mother's pregnancy?		
2. Were any drugs, alcohol or medication taken during mother's pregnancy? Specify:		
Delivery: 1. Was the pregnancy full term?		
2. Was the pregnancy premature? (Give months and weight)		
3. Was it an unusual delivery? (Breech, Caesarian, specify)		
4. Was the labor normal?		
5. Was the labor abnormal? (Prolonged, short, specify)		
6. Were forceps used? (Give details)		
7. Was medication given during delivery? Specify.		

Comments:

Birth History

	Yes	No
1. Was the individual considered to be a low birth weight? Specify.		
2. Were there complications such as: a. cyanosis?		
b. jaundice?		
c. congenital defects?		
d. limpness?		
3. Was there a need for: a. oxygen?		
b. transfusions?		
c. tube feedings?		
4. Were there any feeding difficulties? Specify.		
5. Was your child bottle-fed?		
6. Was your child breast-fed?		
7. Did your child have problems sucking?		
8. Did your child have problems swallowing?		
9. Was the length of your child's stay in the hospital unusually long? Specify.		

Comments:

_____ _____

Occupational Therapist Date

Medical History	Yes	No
1. Has your child had any of the following? a. Meningitis		
b. Measles		
c. Chicken Pox		
d. High Fevers		
e. Mumps		
f. Whooping Cough		
g. Scarlet Fever		
Does your child have any of the following		
i. Diabetes		
j. Lung or Bronchial Difficulties		
k. Heart Trouble		
l. Seizures (indicate when, how often)		
m. Allergies (if yes, to what)		
n. Excessive Vomiting		
o. Tuberculosis		
p. Polio		
q. history of ear infections		
r. use of antibiotics		
s. Physical Injuries/Surgical Procedures? If yes, describe:		
2. Is there a vision difficulty? If yes, describe.		
3. Has there been an eye evaluation and is there a diagnosed visual problem? Date: Optometrist (Please give name) Diagnosis: Ophthalmologist? Developmental Optometrist? Other?		
4. Does the individual have a hearing problem? Had an evaluation? By whom? Date: Describe problem.		
5. Is the individual currently on medication? Medication: Dosage (mg & times/day) Purpose: _____ _____ _____ _____ _____ _____ _____ _____ _____		

Comments:

_____ _____

Occupational Therapist Date

II. **DEVELOPMENTAL HISTORY**

1. At what age did the individual (Please specify ages as near as possible):

a. Roll over both ways?	
b. Crawl?	
c. Sit alone?	
d. Walk?	
e. Speak his/her first word (What was it?)	
f. Drink from a cup independently?	
g. Feed him/herself independently?	
h. Dress him/herself independently?	

Use the following key to mark your responses:

Always: when presented with the opportunity, the individual responds in the manner *almost every time, 90-100%*
Frequently: when presented with the opportunity, the individual *usually* responds in this manner,*at least* 50-*75%* of the time.
Occasionally: when presented with the opportunity, the individual responds in this manner *at least 30 % - 40%* of the time.
Seldom: when presented with the opportunity, the individual usually doesn't respond in this manner, *less than 25%* of the time.
Never: when presented with the opportunity, the individual never responds in this fashion, *0%* of the time

2. Describe infancy:

	ALWAYS	FREQ	OCC	SELDOM	NEVER	N/A
a. Cried a lot, fussy, irritable, colicky?						
b. Was good, non-demanding?						
c. Slow to calm?						
d. Fussy eater?						
e. Was alert?						
f. Was quiet?						
g. Was passive?						
h. Was active?						
i. Liked being held?						
j. Was floppy when held?						
k. Was tense when held?						
l. Had good sleep patterns?						
m. Had irregular sleep patterns?						

Comments:

III. ENVIRONMENT

Socio cultural/ family context (child lives with parent(s), siblings, culture, pets) _____

_____

_____

What type of dwelling do you live in? (apartment, 2 storey house, etc)

_____

Does your child have any problems moving around in your home?

_____

Community support (support groups, volunteer, religious groups, social meetings, etc):

_____

_____

IV. OCCUPATION

A. SELF CARE

In the following chart tick the appropriate box to indicate your level of independence in doing the following activities of daily living**.**

Legend:
I = independent (able to do the activity alone without cuing)

S=supervision (need someone or something to remind them)

A=assistance (mostly do the activity but someone helps– mark who in the comments)

D=dependent (unable to do this and require someone else to do it completely)

N/A= not applicable

Are you able to:	I	S	A	D	N/A	Comments
Bathe yourself						
Dress (indoor clothing)						
Dress (outdoor clothing)						
Use the toilet						
Feed yourself						
Groom (brush hair, teeth, shave)						
Mobility (walk around)						
	I	S	A	D	N/A	Comments
Chores						

_____ _____

Occupational Therapist Date

How does your child spend a typical day from the moment they get up to the moment they go to bed?

_____

_____

_____

_____

Sleep

Describe the child's sleep habits (awake and bedtimes, sleep through the night, hours of sleep, ability to fall asleep, etc)

_____

_____

B. PRODUCTIVITY

How is your child doing in school?

_____

_____

_____

Any difficulties with handwriting or written communication?

_____

_____

Any difficulties with oral communication?

_____

_____

C. LEISURE

What are their Leisure/Hobbies?

_____

_____

What are your child's strengths:

_____

V. PERSON

Affective/Mental Health:

What is their mood like (feelings of depression, anxiety, etc)_____

_____ _____

Occupational Therapist Date

Check all that apply

Cognition - Any problems with:

____Attention/concentration	____Short term/working memory
____Organization/time management	____Problem solving
____Frustration tolerance	____Judgement
____Impulsivity	____Planning
____Long term memory	____ Other

How is your child's behaviour:_____

_____

Physical

Any problems with:

Gross Motor skills _____

Fine motor (using their hands) _____

Strength (in arms or legs) _____

Coordination _____

Does your child have:
- ☐ Right Hand Preference
- ☐ Left Hand Preference

Sensory functions – List any difficulties with

Sound/listening _____

Vision _____

Touch _____

Smell _____

Taste _____

Balance _____

Awareness of your body in space (bumping into things) _____

Awareness of inside body (recognize pain, hunger, thirst, feelings) _____