Beckman and Associates

Occupational Therapy Intake Sheet Form

Name: ____ Date of Birth: _______________________

Address: ____

E-Mail: ____

Phone: __________________________ Best # to reach you on appt. date: _______________________

Parent / Legal Guardian Names: ____

Medical Diagnosis: ____

Birth History

Born at _____________ week's gestation. Birth weight: __________________

Born by vaginal or cesarean delivery?____

Did your child require NICU care?____

Significant birth, medical, surgical history: ____

____

Medical Background

Current medical condition:____

____

Current medications:____

Any known allergies?:____

Does your child wear glasses?:_______________________ Hearing aides?:________________________

Has your child had a vision screening? If so, results:____

Has your child had a hearing screening? If so, results:____

Does your child have an history of ear infections?____

Has your child had tubes placed in the ears?:____

Current concerns for your child: ____

Therapy History

Therapies currently receiving:____

Therapies received in the past:____

Social Background

Currently attending school/grade:____

Academic strengths/weaknesses:____

Primary caregivers during the day:____

Child lives with:____

Child's Current Level of Function

Sensory Processing

Does your child seem over or under sensitive to sensory input?

Sounds:____

Touch:____

Movement:____

Light:____

Pain:____

Temperature:____

Clothing:____

Play Skills

Does your child make friends easily, play well with others? Describe: ______________________

____

Can your child swim? ________________ Ride a bicycle? ________________

Can your child follow Simple directions?____

Can your child follow Multiple step directions?____

Does your child have Temper Tantrums?____

Self-Care

Please check the box which best describes your child's self-care skills:

	Independently	With a little help (up to 25%)	With some help (Up to 50%)	With lots of help (Up to 75%)	Total help needed (up to 100%)	A Struggle to complete
TAKE OFF:						
Socks						
Shoes						
Pants						
Shirt						
PUT ON:						
Socks						
Shoes						
Pants						
Shirt						
FASTEN:						
Velcro						
Buttons						
Zipper						
Snaps						
Shoe laces						
MEALS:						
Finger feed						
Use fork						
Use spoon						
Use knife						
Drink from cup						
HYGIENE:						
Urinate						
Bowel Movements						
Wash hands						
Brush Teeth						
Brush Hair						
Bathe/Shower						

Completed by: _______________________________________ (Sign your name) Date: ___________________