Add Therapy Center

Occupational Therapy Intake Form

Physician's Name:_____

Phone :_____

Email: :_____

What led you to seek Occupational Therapy services for your child? _____

_____

_____

Please check all that apply, and describe your concerns about your child.

Gross Motor:

- ☐ Difficulty with jumping, skipping, running, hopping
- ☐ Difficulty kicking a ball
- ☐ Difficulty throwing and/or catching a ball
- ☐ Appears weaker than peers, fatigues easily
- ☐ Avoids or has difficulty playing on playground equipment
- ☐ Clumsy, decreased awareness of body in space, bumps into objects and people
- ☐ Difficulty coordinating two sides of the body
- ☐ Appears stiff or awkward during movement
- ☐ Poor posture, frequently leans into things
- ☐ Awkward gait, unsteady walking, toe walking, drags feet
- ☐ Difficulty negotiating the stairs

Concerns: _____

_____

Fine Motor:

- ☐ Difficulty with drawing, coloring, tracing
- ☐ Avoids drawing, coloring, tracing and/or writing
- ☐ Problem holding writing tools (grasp too lose, tight or awkward)
- ☐ Slow in completing table top tasks
- ☐ Slow in completing table top tasks
- ☐ Poor posture while sitting in a chair, leans into desk, fidgets

- ☐ Writing is too dark, light, large, or small
- ☐ Switches hands frequently, appears to have no dominant hand
- ☐ Difficulty using classroom tools such as scissors and glue

Concerns: _____

_____

Tactile/Vestibular Sensory:

- ☐ Avoids getting hands, face, body parts messy with paint, glue, sand, food, etc.
- ☐ Dislikes being close to others, hugged, and/or cuddled
- ☐ Craves touch
- ☐ Seeks putting non-food objects in mouth
- ☐ Seems to have decreased awareness of touch- minimal reaction to pain, food on face
- ☐ Picky eater, sensitive to certain textures
- ☐ Only wears certain clothing/ avoids or dislikes other clothing
- ☐ Fearful of being off the ground
- ☐ Withdraws from touch-strong dislike of grooming activities (hair brushing/ cutting, washing)
- ☐ Dislike loud sounds or is very sensitive to environmental sounds
- ☐ Dislikes playground equipment
- ☐ Avoids movement such as bouncing, swinging, rocking
- ☐ Decreased safety awareness and/ or danger seeking

Concerns: _____

_____

Visual/ Perceptual:

- ☐ Difficulty copying from blackboard, workbook, or paper
- ☐ Loses place or omits word when reading, writing, and/or copying
- ☐ Reverses letters, numbers, words when reading and/or writing
- ☐ Trouble completing age level puzzles
- ☐ Difficulty discriminating shapes, letters, numbers
- ☐ Difficulty copying shapes and forms
- ☐ Uses finger to keep place and guide movement during reading
- ☐ Complains of blurriness
- ☐ Appears to not be looking at what he or she is doing
- ☐ Difficulty throwing or kicking a ball at a target

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Concerns: _____

_____

Emotional/Behavioral:

- ☐ Does not like changes to routines
- ☐ Difficulty transitioning between tasks or environment
- ☐ Low frustration tolerance
- ☐ Difficulty socializing/getting along with others
- ☐ Is aggressive in group situations
- ☐ Retreats from social situations/interactions
- ☐ Functions better in small group or one-to-one
- ☐ Difficulty attending to tasks
- ☐ Hyperactive
- ☐ Impulsive

Concerns: _____

_____

Daily Living:

- ☐ Difficulty manipulating zippers and or buttons
- ☐ Trouble putting socks and shoes on and off
- ☐ Unable to tie laces (6 years and older)
- ☐ Difficulty dressing and undressing
- ☐ Difficulty with toileting
- ☐ Trouble washing/drying hands
- ☐ Difficulty brushing teeth independently
- ☐ Difficulty using utensils to feed self
- ☐ Trouble opening containers
- ☐ Finds household chores difficult

Concerns: _____

_____

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