Children's Health and Wellness Center

PEDIATRIC OCCUPATIONAL THERAPY INTAKE FORM

Client Information

Child's Name:		
DOB:	Gender : ❑ F ❑ M	
Home address : Street		Apt :
City :	Province :	Postal Code :

Primary Caregiver(s) :		
Relation :		
Home address (if different): Street :		Apt :
City :	Province :	Postal Code :
Phone number :	Cell :	
Email :		
School and grade :		
Daycare and days/week :		

Emergency contact other than primary caregiver :	
Relation :	
Phone number :	Cell :

Referred by :
Reason for Referral :

Primary language spoken at home : ❑ English ❑ French ❑ Other :
Other language(s) child understands/speaks : ❑ English ❑ French ❑ Other :
Language of instruction at school/daycare: ❑ English ❑ French ❑ Other :

Caregiver concerns :

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Medical Information

Pediatrician :	Phone number :
Address :	
Diagnosis :	
Other disciplines involved :	
Speech therapist Physiotherapist Other	

Please list any medications :

Name	Frequency	Dosage	Reason

Medical History

Gestational age at birth : weeks				Birth Weight :
Delivery :	❑ Vaginal	❑ Planned C-section		❑ Emergency C-section
Presentation :	❑ Head	❑ Face	❑ Breech	❑ Transverse
Assistance :	❑ Forceps	❑ Suction	❑ Other :	
Complications during pregnancy: ❑ Yes ❑ No				
If yes, please describe :				
Complications during birth : ❑ Yes ❑ No				
If yes, please describe :				

Ears : ❑ Infections Number :	❑ Tubes
Musculoskeletal : ❑ Sprain/strain ❑ Fractures ❑ Muscle disorder ❑ Other :_____	
Cardiovascular : q Heart condition : _____	❑ Other :_____
Respiratory : ❑ Frequent colds ❑ Allergies ❑ Asthma ❑ Other : _____-	
Gastrointestinal : ❑ Stomach pain ❑ Constipation ❑ Diarrhea ❑ Vomiting ❑ Other : _____	
Neurological : ❑ Seizures ❑ Head injury/concussion	
Allergies :	
Recent illness :	
Surgical history :	
Has your child received regular immunizations : ❑ Yes ❑ No	
Any reactions to immunizations?	
Vision screening : ❑ Within Normal Limits ❑ Outside of Normal Limits	

Details :
Auditory screening : ❑ Within Normal Limits ❑ Outside of Normal Limits
Details :

Developmental History

Sitting:	
Crawling :	
Walking :	
Running :	
First words :	
3-4 word sentences :	

Activities of Daily Living

Dressing: (dress/undress self; attach zippers, buttons and snap; tie shoes; aversion to textures)

Feeding: (positioning, self-feed, utensil use and type of grasp, food and texture aversions)

Toileting: (toilet training)

Bathing/ Personal hygiene: (independence, opposition, concerns)

Sleeping: (bed time and routine, average hrs sleep/night, nap time and length, difficulties falling asleep)

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Learning and Play :

Hand dominance :	❑ Right ❑ Left ❑ Unsure

Play: (mimicking, imaginative play, parallel play, making friends)

Classroom: (attention problems, problems keep pace in class, special education/classroom adaptations):

Behavior and Communication:

Describe your child briefly: (active, passive, curious, etc.)

How does your child express him or herself? (e.g. verbally, non-verbally)

Behavioural concerns (e.g. distractibility, impulsivity, short attention span, repetitive behaviours, tantrums, aggressive/destructive behaviours, nervous habits, oppositional/defiant behaviours)

Emotional concerns (e.g. fears, anxiety, frequent nightmares, poor self esteem)

Anything else to know about your child?