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:_____

Address: _____

_____

_____

Diagnosis: (if applicable)_____

_____

_____

Who provided diagnosis? _____

What age was diagnosis given? _____

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

Grade:_____

School:_____

Parents Names:_____

How did you hear about OT services?

_____

_____

Client/Parent/Teacher concerns_____

_____

_____

What are you hoping to have resolved?

_____

_____

_____

_____ _____

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 the individual bottle-fed?		
6. Was the individual breast-fed?		
7. Did the individual have problems sucking?		
8. Did the individual have problems swallowing?		
9. Was the length of the individual's stay in the hospital unusually long? Specify.		

Comments:

_____ _____

Occupational Therapist Date

Medical History	Yes	No
1. Has the individual had any of the following? Please indicate whether the individual had the illness or was immunized. a. Meningitis		
b. Measles		
c. Chicken Pox		
d. High Fevers		
e. Mumps		
f. Whooping Cough		
g. Scarlet Fever		
i. Diabetes		
j. Lung or Bronchial Difficulties		
k. Heart Trouble		
l. Seizures (indicate when, how often)		
m. Allergies		
n. Excessive Vomiting		
o. Tuberculosis		
p. Polio		
q. 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: Evaluated by Whom? (Please give name) Diagnosis: Ophthalmologist? Developmental Optometrist? Other?		
4. Does the individual have a hearing problem? Had an evaluation? By whom? Date: Describe problem. Has individual received any Listening Intervention Program? Name of program_____ Where?_____ Dates?_____ Other treatment?		
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. Speak his/her first sentence (What was it?)	
g. Drink from a cup independently?	
h. Use a spoon independently?	
i. Feed him/herself independently?	
j. Put on a shirt independently?	
k. Button independently?	
l. 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:

3. Describe the individual presently; emotional / relational issues:

Is the individual…?:

	ALWAYS	FREQ	OCC	SELDOM	NEVER	N/A
1. Mostly quiet, shy?						
2. Overly active?						
3. Self-absorbed?						
4. Tire easily?						
5. Talk constantly?						
6. Have poor impulse control?						
7. Restless?						
8. Stubborn, rigid, uncooperative, oppositional?						
9. Resistant to changes?						
10. Overreact & seem easily overwhelmed?						
11. Have difficulty being calmed once upset, or is unable to unwind and self-calm?						
12. __Argue a lot, __ express hostility, ___fight frequently?						
13. Usually happy?						
14. Have nervous habits or tics? If so describe:						
15. Have poor attention span?						
16. Frustrated easily?						
17. Have unusual fears, which may interfere with daily routines? Describe:						
18. Have sleep problems: sleeps overly much or not enough; trouble waking or trouble falling asleep?						
19. Rock self frequently?						
20. Clumsy?						
21. Have frequent temper tantrums, become quickly angered, explosive, easily enraged?						
22. Fall often?						
23. Apt to say, 'Everything drives me crazy'?						
24. Depressed, overly/easily discouraged?						
25. Tend to want to be in charge, be bossy or refuse to interact/play if it's not done their way?						
26. Blame others, unable to take responsibility for actions?						
27. Have difficulty making friends?						
28. (If a child) Prefers the company of older individuals or younger children?						
29. Self-isolate, withdrawn?						
30. Not interested or easily engaged with others?						
31. Avoid eye contact?						
32. Seem to have difficulty liking self, lacking self-confidence, apt to chastise self for being stupid?						
33. Lack a sense of humor, is overly serious?						
34. (Child) wets bed?						
35. As a child has/had trouble 'growing up'?						
36. Have difficulty learning new tasks (i.e. writing, throwing a ball, riding a bike, chores, work tasks, etc.)?						

_____ _____

Occupational Therapist Date

Describe the Individual Presently (cont.):	ALWAYS	FREQ	OCC	SELDOM	NEVER	N/A
37. Use inefficient ways of doing things?						
38. Need more protection from life than other individuals?						
39. Seem accident-prone?						
40. Become overly affectionate with others?						
41. Sensitive to criticisms?						
42. Have pronounced mood swings?						
43. Overly anxious much of the time, even with crippling anxiety, panic attacks?						
44. Display emotional outbursts when unsuccessful at a task?						
45. Have difficulty tolerating and feels out of control with changes in plans, expectations, or unpredictable situations?						
46. Have difficulty transitioning from one situation to the next?						
47. Dislike new situations?						
48. Express feeling like a failure, low self-esteem?						
49. A perfectionist and must do it just so or not at all?						
50. Have nightmares?						
51. Cry easily?						
52. Poor frustration tolerance?						
53. Have difficulty expressing emotions?						
54. Have difficulty separating from primary caretaker?						
55. Have difficulty perceiving/reading others' body language or facial expressions?						
56. Attempt to self-calm with 'self-stimming'? Describe:						
57. Act out aggressively? Please check appropriate: Hitting____, Scratching____, Kicking ____, Biting ____, and Other _____.						
58. Have episodes of self-injurious, self-mutilating behavior? Describe:						
59. Overly impatient?						
60. Moody?						
61. Have emotions lacking in range, depth, or apt to be inappropriate (too much, too little) in relationships?						

Comments:

_____ _____

Occupational Therapist Date

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

I. SELF CARE AND PRODUCTIVITY

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	S	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 (sleep through the night, hours of sleep, ability to fall asleep, etc)

_____

_____

Communication Skills:

Any difficulties with written Communication?

_____

_____

Any difficulties with Oral Communication?

_____

_____

What are their Leisure/Hobbies?

_____

_____

Strengths:

_____

V. PERFORMANCE COMPONENTS

Check all that apply

Cognition - Any problems with:

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

_____ _____

Occupational Therapist Date

Behaviour:_____

Affective/Mental Health:

Any feelings of depression, anxiety,etc:_____

_____

Physical

Check all that apply

Any problems with:

____Moving arms around
____Moving legs
____Using your hands
____Balance
____Strength
____Coordination

Is your child have:
□ Right Hand Preference
□ Left Hand Preference

Sensory functions – List any difficulties with:

Touch _____

Smell _____

Taste _____

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

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

Are there any other things that you would like to add?

_____

_____

_____

_____ _____

Occupational Therapist Date