A+ Handwriting
Occupational Therapy

Background Information and Occupational Intake Form

----------**Family Information**----------

Child's name_____

Birth Date_____ Age _____ Home/Cell Phone Number _____/_____

Parent's name _____

Address _____

Email _____

----------**Referring Information**---------

Who referred this child for an evaluation? _____

Reason for referral? _____

What are your primary concerns/goals for therapy regarding your child?

_____

_____

_____

What are your child's strengths?

_____

_____

_____

----------**School History**----------

School Name and Teacher:

_____

Grade: _____ Hand preference: ☐ Right ☐ Left ☐ Both

Does your child receive special instruction or have an established IEP? ☐ no ☐ yes

School based therapy? ☐ OT ☐ PT ☐ Speech and Language

Homeschooled? _____ How long homeschooled? _____

----------**Medical History**----------

Any difficulties during pregnancy or delivery? □ No □ Yes If Yes please specify:

_____

_____

_____

Length of pregnancy: _____ Birth was: □ Vaginal □ Caesarean □ Breech

Chronic ear infections? □ no □ yes □ tubes placed __ sets of tubes

Current prescribed medications: _____

Known food allergies: _____

Special Diet (GFCF, Ketogenic, pureed food only, tube feeding, etc.):

_____

Medical precautions: _____

Diagnosis given by other health care professionals?

_____

Hospitalizations, date and length of stay:

_____

_____

Surgeries? _____

Currently receiving services from other health care professionals:

□ Psychologist □ PT □ Speech and Language □ Nutritionist □ Behavioral Specialist □Other: _____

----------**Developmental History**----------

Please check all the developmental milestones that your child *achieved*:

□ rolling □ sitting alone □ creeping on all 4's □ pull to stand □ walking

□ first word: _____(age) □ combined words:_____(age) □ finger feeding

□eating with a spoon □ cutting with a knife □ cutting with scissors □ jumping

□ hopping on one foot □ riding a bike

Developmental milestones were met: □ within typical age ranges □ delayed

Sleeping Issues? _____

Motion Sickness? _____

Headaches? _____

Please check the amount of assistance needed for your child to complete the following:

Self care:	Independent (completes without help)	I assist 50% or more	Dependent (total assistance needed)
Takes off pants:	□	□	□
Puts on pants:	□	□	□
Takes off shirt:	□	□	□
Puts on shirt:	□	□	□
Buttons:	□	□	□
Zipper:	□	□	□
Snaps:	□	□	□
Puts on shoes:	□	□	□
Takes off shoes:	□	□	□
Ties shoes:	□	□	□
Puts on socks:	□	□	□
Takes off socks:	□	□	□
Toileting:	□	□	□
Bathing routine:	□	□	□
Tooth brushing:	□	□	□
Scooping with a spoon	□	□	□
Spears with a fork	□	□	□
Drinks from open cup	□	□	□
Drinks from straw	□	□	□

Describe your child at present:

	Yes	**No**	**Sometimes**
Mostly quiet	□	□	□
Overly active	□	□	□
Tires easily	□	□	□
Talks constantly	□	□	□
Too impulsive	□	□	□
Restless	□	□	□

	Sometimes	Yes	No
Stubborn	☐	☐	☐
Resistant to change	☐	☐	☐
Fights frequently	☐	☐	☐
Usually happy	☐	☐	☐
Exhibits temper tantrums (describe:)	☐	☐	☐
Clumsy	☐	☐	☐
Nervous ticks/habits	☐	☐	☐
Wets bed (frequency:)	☐	☐	☐
Poor attention	☐	☐	☐
Frustrated easily	☐	☐	☐
Unusual fears (list:)	☐	☐	☐
Rocks self frequently	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Difficulty staying asleep	☐	☐	☐
Sluggish in the mornings	☐	☐	☐

----------Social and Occupational History----------

Does your child:

	Often	Sometimes	Rarely
Socialize with family and close friends?	☐	☐	☐
Communicate needs and wants effectively?	☐	☐	☐
Hard to make friends?	☐	☐	☐
Tend to interact/play with younger children?	☐	☐	☐
Enjoy time alone?	☐	☐	☐
Tolerate change in routine?	☐	☐	☐

Please describe any other concerns about your child:

_____
_____
_____
_____

Thank you for providing this valuable information. It will help streamline the evaluation process.

Marla Scaglione, MS, OTR/L
Pediatric Occupational Therapist
A+ Handwriting
www.APlusHandwriting.com
https://www.facebook.com/APlusHandwriting/