Achievement Therapy Center, LLC
Therapy for Children
235 E. 9th Ave. Anchorage, AK 99501
(907) 334-9001
atherapycenter@gmail.com • FAX (907) 868-8657
www.TherapyForChildren.net

OCCUPATIONAL THERAPY INTAKE **Patient Name** _____

At what age did your child demonstrate the following?

sitting up _____ crawling _____ standing _____ walking _____

finger feeding _____ eating with spoon _____ potty-trained _____ undressing self _____

ACTIVITIES OF DAILY LIVING

Does your child dress him/herself? YES NO

If not, how do they assist you? _____

Does your child feed him/herself? YES NO

If not, how do they assist you? _____

Does your child eat neatly for his/her age? YES NO

Does your child use utensils appropriately? YES NO

If not, please describe: _____

Does your child brush his/her teeth? YES NO

If not, please describe: _____

Does your child display sensitivity to clothing, food textures or sounds? YES NO

If yes, please describe and explain how you have accommodated this: _____

Please circle if your child is able to complete the following independently?

Tie Shoes Button buttons Zipper Coat Snap pants or jackets

Elaborate if necessary: _____

Where does your child typically eat, i.e. at the table, high chair, living room?

Additional comments: _____

_____

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FINE MOTOR SKILLS

Is your child able to write legibly/age appropriately? YES NO

If no, please describe difficulties: _____

Does your child hold utensils in his/her hands: too tightly or too loosely. Circle one if it applies.

Does your child have a dominant hand? Right Left No Circle one that applies.

Additional comments: _____

_____

GROSS MOTOR SKILLS & BODY AWARENESS

Did your child spend much time in car seats while not in the car? YES NO

Did your child enjoy baby swings as an infant, the kind that plays music, etc. and sets inside house? YES NO

Did your child crawl? YES NO On hand/knees or slide on belly? For how long before walking?

Explain: _____

Did your child walk before 10 months? YES NO

Or start walking after 15 months? YES NO

Does your child bump into things? YES NO

Does he/she trip or fall a lot? YES NO

Does he/she seem awkward or clumsy? YES NO

Are your child's movements slow and deliberate? YES NO

Can your child skip? YES NO

Ride a bike? YES NO

Hop on One Foot? YES NO

Does your child bump into objects and other people on purpose? YES NO

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GROSS MOTOR SKILLS & BODY AWARENESS *continued*

Does your child slump when sitting? YES NO

Does your child seem weak or strong? Circle one that applies.

Do your child's muscles feel firm, rigid or soft? Circle one that applies.

Additional comments:

_____

_____

ORAL

Does your child avoid any foods? _____

Does your child seem overly sensitive to smells? YES NO

What types of foods does your child like?

_____

_____

Does your child have any feeding/swallowing problems? YES NO

If yes, please describe: _____

Additional comments: _____

_____

_____

VISUAL

Does your child have any diagnosed visual problems? YES NO

If yes, please describe: _____

When was the last time your child had his/her vision assessed and by whom? _____

_____

Has your child been evaluated for or received vision therapy? If yes, when / with whom? _____

_____

Is your child able to close his/her eyes for short periods of time? YES NO

Is your child distracted in a "busy" room? YES NO

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VISUAL *continued*

Does your child enjoy puzzles? YES NO

What type of puzzles can he/she complete successfully alone? _____

Does your child look at you and others when you are talking? YES NO

Does your child appear not to notice things in their environment? YES NO

Does your child like to look at books? YES NO

Additional comments: _____

_____

_____

_____

BEHAVIOR/TEMPERAMENT

Please describe your child's personality.

_____

_____

How do you handle behavior problems or tantrums at your house?

_____

_____

Does your child have tantrums? YES NO How often?

Is your child an early riser or slow to get going? Circle one that applies.

Does your child like a routine? YES NO

Is he/she bothered by breaks in routine? YES NO

Can your child play alone? YES NO

Does your child play alone all of the time? YES NO

Who does your child prefer to play with? _____

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BEHAVIOR/TEMPERAMENT *continued*

Does your child demonstrate self-stimulating behaviors? YES NO

If yes, please describe: _____

Please describe your child's daily routine:

_____

_____

_____

What is your child's nighttime routine?

_____

_____

_____

Does your child sleep through the night? YES NO

Does your child wake during the night? YES NO

Does your child sleep in their own bed? YES NO

Does your child have difficulty going to sleep? YES NO

What is your favorite thing about your child? _____

_____

_____

What do you find frustrating about your child? _____

_____

_____

What are your child's favorite toys? _____

Where does he/she like to play? _____

Does your child have any favorite games or activities? _____

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BEHAVIOR/TEMPERAMENT *continued*

How is your child doing at school? What is your child's attitude towards school? _____

_____

_____

Does your child have an IEP/IFSP? YES NO If yes, please provide a copy.

What would you like for your child to accomplish while receiving Occupational Therapy?

_____

_____

_____