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NEW HORIZONS
WELLNESS SERVICES, LLC

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Occupational Therapy Intake Form

NEW CLIENT INFORMATION				
Date:	**Patient Name:**	**Gender:** ☐ M ☐ F	**DOB:**	**Age:**
Person Completing Form:		**Relationship:**		

PREVIOUS SERVICES

Type of Service	Yes or No	Date(s)	Therapy Provider
Speech/Language Therapy	☐ Y ☐ N		
Occupational Therapy	☐ Y ☐ N		
Physical Therapy	☐ Y ☐ N		
Psychological/Behavioral/Counseling	☐ Y ☐ N		
Other Specialists:	☐ Y ☐ N		

DIAGNOSIS (check all that apply)

- ☐ Autism spectrum disorder/Asperger's Syndrome
- ☐ ADD/ ADHD (Attention Deficit Disorder)
- ☐ Sensory processing disorder or sensory integration dysfunction
- ☐ Anxiety or emotional disorder(s) Specify: _____
- ☐ Other Specify: _____
- ☐ Cerebral Palsy
- ☐ Genetic disorder
- ☐ Learning disability
- ☐ Down syndrome
- ☐ Intellectual Disability

Who provided the above diagnosis and what criteria that diagnosis was based on (i.e.: test scores, comprehensive clinical evaluation, genetic study, etc.):

CHILDHOOD ILLNESSES/PROBLEMS
Check all problems that apply to your child and provide details:

Illnesses/Problems	Age	Comments
Pressure equalizing (PE) tubes in ears		
Allergies		
Immunizations		
Asthma/Bronchitis		
Skin problems		
Gastro-intestinal problems		
Seizures/Epilepsy		
Nail biting		
Broken limbs		
Other		

List all current medications:

List any vision/hearing evaluations/treatment:
Has the child ever had a serious accident/injury? ☐ Y ☐ N **Explain:**
Is the child currently in good general health? ☐ Y ☐ N **If no, please explain:**
Does your child have any self-injurious behavior(s)?
Does your child ever lash out at others physically when frustrated or at any other time?
Does your child have any specific fears of which we should be aware?
What are your child's gifts/strengths/interests?

Please check the box which best describes your child's self-care skills:

	Independently	**With a little help (up to 25%)**	**With some help (Up to 50%)**	**With lots of help (Up to 75%)**	**Total help needed (up to 100%)**
TAKE OFF/PUT ON:					
Socks					
Shoes					
Pants					
Shirt					
FASTEN:					
Velcro					
Buttons					
Zipper					
Snaps					
Shoe laces					
MEALS:					
Finger feed					
Use fork					
Use spoon					
Use knife					
Drink from cup					
HYGIENE:					
Hand Washing					

Tooth Brushing					
Hair Brushing					
Showering					
TOILETING:					
Hygiene					
Clothes management					
CHORES					
SLEEP:					
Follow bedtime routine					
Sleep through the night? How many hours?					
Nightmares?					
Bedwetting					
Wakes in morning with ease?					

Does your child attend daycare or school? If so, which facility and grade does your child attend?

What concerns do you have regarding your child at school?

List concerns your child's teacher/daycare provider have reported:

What solutions have been attempted at home and at school?

Does your child have an IEP/IFSP? ☐ Y ☐ N (If yes, please bring a copy to the evaluation)

GROSS AND FINE MOTOR SKILLS

Check all that apply to your child and provide details:

- ☐ Seems weaker or tires more easily than peers
- ☐ Appears stiff, awkward, or clumsy in movement
- ☐ Seems to have great difficulty learning new motor tasks
- ☐ Difficulty learning how to ride a bike without training wheels
- ☐ Difficulty playing with small manipulative toys (i.e.: Legos, etc.)
- ☐ Sits in "W" position
- ☐ Dislikes coloring or paper/pencil tasks
- ☐ Difficulty learning how to swim
- ☐ Dislikes working puzzles, easily frustrated
- ☐ Difficulty with scissors
- ☐ Difficulty catching a ball
- ☐ Difficulty kicking a ball
- ☐ Difficulty pumping self on swing

Details:

MOVEMENT AND BALANCE

Check all that apply to your child and provide details:

- □ Has trouble or hesitancy in learning to climb/descend stairs
- □ Dislikes being lifted up and gently toss in the air by parent
- □ Did/does not life being placed on stomach as infant
- □ Is nauseated/vomits from movement experiences (swings, etc.)
- □ Is unable to give adequate warning about nausea
- □ Rocks back and forth when stressed
- □ Hesitates to climb or play on playground equipment
- □ Crawling period absent/very brief
- □ Walks or walked on toes
- □ Gets car sick frequently
- □ Seeks twirling or spinning
- □ Seeks amusement park rides/swings
- □ Is constantly moving or "on the go"
- □ Trips or falls frequently

Details:

TREATMENT GOALS

What are 3 problems that you would like to see addressed in OT and rate how much of a problem they are currently.

1.)

2.)

3.)