Edward Rehab Services

OCCUPATIONAL THERAPY PEDIATRIC INTAKE ASSESSMENT

Please complete this form to help us better meet the needs of the patient.

Date: _____

Completed by: _____ Relationship to child: _____

Child's name: _____

Child's Diagnosis: _____

Primary reason for this visit:

_____

Please comment on the child's medical history (including any allergies or medications):

_____

_____

With whom does the child live? _____

Does the child attend school? If yes, please list grade & school: _____

Please list all areas of concern: _____

_____

	YES	NO
Does the child have difficulty interacting socially with peers?		
Does the child have frequent tantrums?		
Does the child have any visual impairment?		
If yes, please explain: _____		
	RIGHT	LEFT
What is the child's preferred writing hand?		

Has the child ever received occupational therapy, speech therapy or physical therapy prior to this appointment? If yes, please list which service, when and how often: _____

_____

What are the child's interests? _____

Does the child have any dislikes? _____

What are your main goals for therapy? _____

_____

_____

Is the child able to complete the following with/without physical assistance? (Please mark X)

	With assistance	Without assistance
Putting clothing on		
Taking clothing off		
Buttoning		
Zippering		
Shoe Tying		
Self-feeding		
Brushing teeth		
Toileting		

Does the child have difficulty with the following? (Please mark X)

	Yes	No
Paying attention		
Following Directions		
Putting things in order		
Comprehension		
Expression		
Flexibility		
Memory		
Initiation		
Thinking speed		
Safety awareness		
Problem Solving		

Does the child have difficulty with the following? (Please mark X)

	Yes	No
Strength		
Balance		
Coordination		
Handwriting		
Scissor skills		
Grasping objects		
Ball play		