



Pediatric Occupational Therapy Intake Questionnaire (Ages 1-21)

****The more info provided, the better your therapist can understand your child and help meet your goals!**

<i>Child's Name:</i>	<i>Date of Birth:</i>	<i>Age:</i>
<i>School/Daycare:</i>	<i>Pediatrician:</i>	<i>Diagnoses:</i>
Reason for OT/Feeding Therapy Evaluation: *Has your child ever received any other services? (Physical therapy, speech therapy, occupational therapy, psychotherapy/counseling, etc.—please provide details).		

Birth History:

Delivery? (Vaginal or Cesarean)	Any Complications? (premature, jaundice, trouble breathing, trouble feeding)	How long in Hospital? NICU Stay?
Breast or Bottle fed?	Any Trouble with Feeding?	Comments:

Medical History

My child has a history of:	NO	Yes-Please explain
Allergies		
Torticollis		
Tongue or Lip Tie		
Heart or Lung Problems		
Hormone, metabolic, or endocrine challenges		
Hearing challenges		
Vision challenges		
Medications		
Surgeries or Hospitalizations		



Developmental History

Developmental Skill	Age Mastered
Rolling both ways	
Sitting alone	
Walking	
Spoke first word/first sentence	
Feeding self with utensils	
Dressing	
Hygiene (toileting, bathing, tooth brushing, grooming)	
Crawling	What age started? Age stopped?

Behavior

My Child...	NO	Yes	Comments
Is usually happy			
Is usually active			
Is often lethargic			
Follows multi-step directions			
Transitions well			
Tolerates changes in routine			
Has decreased safety awareness			
Is clumsy			
Has difficulty managing emotions			
Tantrums Easily			Occurrences per day _____; Duration of tantrum _____
Comments:			
Likes: Dislikes:			



Fine Motor Skills

My Child...	NO	Yes	Comments
Has difficulty playing with or manipulating small items			
Has difficulty sustaining a grasp on pencils, utensils, or small items			
Drops items frequently			
Complains of hand fatigue			
Comments:			

Gross Motor Skills

My Child...	NO	Yes	Comments
Can hop on 1 foot			
Can ride a bicycle			
Has difficulty with throwing/catching			
Has difficulty playing on playground equipment			
Comments:			



My Child...	NO	Yes	Comments
Independently completes dressing routines			
Independently completes hygiene			
Independently completes feeding			
Falls asleep independently			
Sleeps through the night			
Comments:			

Sensory Processing

My Child...	NO	Yes	Comments
Tolerates playing with or touching messy textures			
Tolerates unexpected touch			
Is resistant to certain clothing			
Is a picky eater			
Is sensitive to temperature			
Overreacts to sudden/unexpected sounds			
Overreacts/avoids loud sounds (toilet flush, hand dryer, etc.)			
Has difficulty focusing with background noise			
Has trouble finding			



objects in a busy background (drawer, refrigerator, desk, toy bin, etc.)			
Overreacts to bright lights			
Has strong preferences for certain tastes (salty, sour, sweet, cold, etc.)			
Overreacts to smells			
Chews food for longer than expected before swallowing			
Is potty trained			
Has difficulty with bed wetting			
Has accidents			
Is often constipated			
Bumps into objects or others when walking			
Is clumsy or accident prone			
Seeks out movement			
Experiences motion sickness			
Frequently loses balance			
Comments:			

***If receiving services for feeding therapy, please complete “Food Log” intake form as well.**