



## Occupational Therapy Intake Form

What led you to seek Occupational Therapy services for your child? \_\_\_\_\_

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Please check all that apply, and describe your concerns about your child.

### Gross Motor:

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulty with jumping, skipping, running, hopping                         | <input type="checkbox"/> Difficulty coordinating two sides of the body           |
| <input type="checkbox"/> Difficulty kicking a ball   | <input type="checkbox"/> Appears stiff or awkward during movement                |
| <input type="checkbox"/> Difficulty throwing and/or catching a ball                                  | <input type="checkbox"/> Poor posture, frequently leans into things              |
| <input type="checkbox"/> Appears weaker than peers, fatigues easily                                  | <input type="checkbox"/> Awkward gait, unsteady walking, toe walking, drags feet |
| <input type="checkbox"/> Avoids or has difficulty playing on playground equipment                    | <input type="checkbox"/> Difficulty negotiating the stairs                       |
| <input type="checkbox"/> Clumsy, decreased awareness of body in space, bumps into objects and people |  |

Concerns: \_\_\_\_\_

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### Fine Motor:

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulty with drawing, coloring, tracing                        | <input type="checkbox"/> Slow in completing p tasks                                      |
| <input type="checkbox"/> Avoids drawing, coloring, tracing and/or writing                  | <input type="checkbox"/> Poor posture while sitting in a chair, leans into desk, fidgets |
| <input type="checkbox"/> Problem holding writing tools (grasp too loose, tight or awkward) | <input type="checkbox"/> Difficulty using classroom tools such as scissors and glue      |
| <input type="checkbox"/> Writing is too dark, light, large, or small                       |  |
| <input type="checkbox"/> Switches hands frequently, appears to have no dominant hand       |  |

Concerns: \_\_\_\_\_

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### **Tactile/Vestibular Sensory:**

- |  |   |
|--|---|
| <input type="checkbox"/> Avoids getting hands, face, body parts messy with paint, glue, sand, food, etc.   | <input type="checkbox"/> Fearful of being off the ground  |
| <input type="checkbox"/> Dislikes being close to others, hugged, and/or cuddled                            | <input type="checkbox"/> Withdraws from touch-strong dislike of grooming activities (hair brushing/ cutting, washing) |
| <input type="checkbox"/> Craves touch  | <input type="checkbox"/> Dislike loud sounds or is very sensitive to environmental sounds                             |
| <input type="checkbox"/> Seeks putting non-food objects in mouth   | <input type="checkbox"/> Dislikes playground equipment  |
| <input type="checkbox"/> Seems to have decreased awareness of touch-minimal reaction to pain, food on face | <input type="checkbox"/> Avoids movement such as bouncing, swinging, rocking  |
| <input type="checkbox"/> Picky eater, sensitive to certain textures  | <input type="checkbox"/> Decreased safety awareness and/ or danger seeking  |
| <input type="checkbox"/> Only wears certain clothing/ avoids or dislikes other clothing                    |   |

Concerns: \_\_\_\_\_

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### **Visual/ Perceptual:**

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulty copying from blackboard, workbook, or paper          | <input type="checkbox"/> Difficulty copying shapes and forms                         |
| <input type="checkbox"/> Loses place or omits word when reading, writing, and/or copying | <input type="checkbox"/> Uses finger to keep place and guide movement during reading |
| <input type="checkbox"/> Reverses letters, numbers, words when reading and/or writing    | <input type="checkbox"/> Complains of blurriness                                     |
| <input type="checkbox"/> Trouble completing age level puzzles                            | <input type="checkbox"/> Appears to not be looking at what he or she is doing        |
| <input type="checkbox"/> Difficulty discriminating shapes, letters, numbers              | <input type="checkbox"/> Difficulty throwing or kicking a ball at a target           |

Concerns: \_\_\_\_\_

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## **Occupational Therapy Intake Form**

### **Emotional/Behavioral:**

- |  |  |
|--|--|
| <input type="checkbox"/> Does not like changes to routines                     | <input type="checkbox"/> Retreats from social situations/interactions  |
| <input type="checkbox"/> Difficulty transitioning between tasks or environment | <input type="checkbox"/> Functions better in small group or one-to-one |
| <input type="checkbox"/> Low frustration tolerance                             | <input type="checkbox"/> Difficulty attending to tasks                 |
| <input type="checkbox"/> Difficulty socializing/getting along with others      | <input type="checkbox"/> Hyperactive                                   |
| <input type="checkbox"/> Is aggressive in group situations                     | <input type="checkbox"/> Impulsive                                     |

Concerns: \_\_\_\_\_  
\_\_\_\_\_

### **Daily Living:**

- |   |  |
|---|--|
| <input type="checkbox"/> Difficulty manipulating zippers and or buttons | <input type="checkbox"/> Difficulty brushing teeth independently |
| <input type="checkbox"/> Trouble putting socks and shoes on and off     | <input type="checkbox"/> Difficulty using utensils to feed self  |
| <input type="checkbox"/> Unable to tie laces (6 years and older)        | <input type="checkbox"/> Trouble opening containers              |
| <input type="checkbox"/> Difficulty dressing and undressing             | <input type="checkbox"/> Finds household chores difficult        |
| <input type="checkbox"/> Difficulty with toileting                      | <input type="checkbox"/> Difficulty with sucking or swallowing   |
| <input type="checkbox"/> Trouble washing/drying hands                   |  |

Concerns: \_\_\_\_\_  
\_\_\_\_\_