Bird-Kern-Dalmia
Speech Language and Occupational Therapy
1101 S. Winchester Blvd. E 155
San Jose, CA 95128
www.birdkernanddalmia.com (408)379-0245

Occupational Therapy Intake Form

General Information:

Client Name: ____

Date of Birth: ______________________ Age: ______________

Mother's Name: ______________________ Phone Number: ______________

Address: ____

E-Mail: ____

Mother's Employer: ____

Father's Name: ______________________ Phone Number: ______________

Address: ____

E-Mail: ____

Father's Employer: ____

Pediatrician: ______________________ Phone Number: ______________

Medical History:

Does your child have a diagnosis given by another professional? ☐ Yes ☐ No

Diagnosis: ____

Pregnancy Duration: ______________ Delivery: ☐ Vaginal ☐ C-Section ☐ Breech

Complications: ☐ Yes ☐ No If yes, please explain:
____

____

Number of Ear Infections: ________ Treatment: ______________________

Current Medications: ____

Known Allergies: ____

Special Diet: _________________________________ Surgeries? ______________________________

Is your child currently receiving any of the following services?

☐ OT ☐ PT ☐ Speech ☐ Psychologist ☐ Behaviorist ☐ Nutritionist ☐ Other

If yes, please list provider: ____

____

Developmental History:

Please list the approximate age your child did the following:

________ roll front to back ________ roll back to front ________ sit unsupported ________ crawl

________ pull to stand ________ cruise furniture ________ walk unassisted ________ run

________ hold cup or bottle ________ finger feed ________ use fork or spoon

________ dress self ________ tie shoes ________ toilet trained

Please list any over or under sensitivity you notice in the following areas:

Tactile (clothes, teeth/hair brushing, sand play, food, etc.): _____________________________________

____

____

Visual (doesn't notice things, easily distracted, overwhelmed by crowds, etc.): ____________________

____

____

Auditory (things are too loud, makes excessive noise, etc.): ____________________________________

____

____

Vestibular (always moving, gets car sick, fearful of swings/slides, etc.) __________________________

____

Proprioceptive (clumsy, runs into things/people, rough play, etc.): ______________________________

____

____

Internal sensation (hunger, thirst, cold, etc.): ____

____

____

School History:

Current School: ____ Grade: __________________

Does your child receive special instruction or have an IEP? ☐ Yes ☐ No

If yes, what areas do they receive support in? ____

____

Has your child's teacher expressed concerns about academic performance? ☐ Yes ☐ No

If yes, please describe: ____

____

____

Leisure History:

Does your child play any sports? ____

____

What activities does your child enjoy? ____

____

What activities does your child avoid? ____

____

Additional Information:

Is there anything else you would like us to know about your child? ______________________________

____

____

____

____

Person filling out this form: ____

Relationship to client: _____________________________ Date: _______________________________