PIN:_____

James Madison University – Occupational Therapy Clinical Education Services

601 University Blvd – MSC 9022, Harrisonburg, VA 22807
131 W. Grace St., Rm 1100
Phone: (540) 568-4980 Fax: (540) 568-3886

Intake Form

Date Completed:_____ Completed by:_____

Child's Name _____ ☐ Female ☐ Male
First Middle Last Nickname

Child's Name at Birth (if different) _____ Child's Date of Birth _____

Mother's Name _____ Father's Name _____

Parents' Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

Child Resides With: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other (specify): _____

Name of Legal Guardian _____
(if different from parent)

Has this child been adopted? ☐ Yes ☐ No

Mother's Address _____
Street City State Zip

Mother's Home Phone (_____) _____ Mother's Cell Phone (_____) _____

Mother's Occupation _____ Work Phone (_____) _____

Mother's email_____

Father's Address _____
Street City State Zip

Father's Home Phone (_____) _____ Father's Cell Phone (_____) _____

Father's Occupation _____ Work Phone (_____) _____

Father's email_____

Legal Guardian's Address _____
(if applicable) Street City State Zip

Legal Guardian's Home Phone (_____) _____ Cell Phone (_____) _____

Legal Guardian's Occupation _____ Work Phone (_____) _____

Legal Guardian's Email_____

PIN:_____

LIST ALL PERSONS LIVING IN THE CHILD'S PRIMARY HOME

Name	Relationship	Age

BROTHERS & SISTERS LIVING ELSEWHERE

Name	Age

Name	Age

Child's School _____
Name of School City State School Division

Grade _____ Teacher _____ Principal_____

If child is home schooled, what school division would he/she attend? _____

Has child ever been evaluated for any special education services ☐ Yes ☐ No

If Yes, Where and When? _____

Does your child currently have an IEP or 504 Plan? ☐ Yes ☐ No If yes, please list what services are being received and provide a copy. _____

Child's Primary Physician:_____Practice:_____

Address:_____Phone:_____
Street City State

How long has your child been seeing this physician?_____

What concerns about your child would you like addressed during the evaluation? _____

_____

_____

_____

Who referred you to our Clinic? _____

If a professional referred you, what concerns would they like addressed during the evaluation? _____

_____

_____

PIN:_____

List ALL professionals that have provided services to your child since birth.

	DATE(S)	REASON/RESULTS
Medical Specialists *(i.e. Neurologist, Gastroenterologist, Ophthalmologist, etc.)*		
Mental Health Professional (Psychiatrist, Psychologist, counselor, etc.)		
Rehab or Developmental Therapist *(OT, SLP, PT, etc.)*		
Other Specialist (vision or hearing impaired, orientation & mobility, etc.)		
Other (Dept of Social Services, case management, etc.)		

If you need additional space, please continue on the back.

Medication History

	Medication	Purpose
Current:		
Previous:		

PIN:_____

PIN:_____

Pregnancy/Birth History

	Yes	No	Comments (if yes, please provide additional information)
Did mother experience any medical complications during pregnancy?			
Did mother take any medications during pregnancy or labor?			
Was the delivery premature?			
Were there any complications during delivery? (i.e. c-section, induced labor, extraction, etc.)			
Were APGAR scores normal at birth?			
Did your child experience any medical complications after birth?			
Did your child have an extended stay at the hospital following birth?			If yes, how long?
Did the child require tube feeding?			If yes, how long?
Was your child breast fed?			If yes, how long?
Did your child have difficulty with feeding?			

What was the child's gestational age and birth weight? Age_____weeks Weight_____lbs_____oz.

Medical History

	Yes	No	Comments (if yes, please provide additional information)
Has your child received a specific diagnosis (i.e. Autism, hypotonia, learning disability, etc.)?			
Does your child have any allergies?			
Does your child have seizures?			
Did your child experience any complications from vaccinations?			
Does your child have any significant medical issues (respiratory, heart, broken bones, stitches, other)?			
Does your child have a history of ear infections?			
Has your child been hospitalized or required surgery?			
Does your child have a history of GI issues (i.e. constipation, chronic diarrhea, reflux, other)?			
Has your child had a vision screening?			Date of screening & results:
Has your child had a hearing screening?			Date of screening & results:
Has your child had a physical exam within the last year?			Date of exam & results:

PIN:_____

Behavior & Organizational History

Does your child:	Yes	No	N/A or Comments
Have extreme mood changes (tantrums, outbursts)?			
Become easily frustrated?			
Lack confidence or give up easily?			
Have difficulty following rules?			
Become easily distracted or difficulty attending to task?			
Have difficulty with changes in routine or resists change?			
Have difficulty transitioning from one activity to another without becoming distressed or unsettled?			
Need to escape to somewhere quiet and secluded when overwhelmed (under a table, in a closet or tent)?			
Mouth, lick or chew on non-food items?			
Require a lot of 1-1 support to be successful in getting things done?			
Frequently complain of not feeling well or physical problems?			
Frequently try to control situations?			
Have difficulty with organizational skills?			

Auditory/Language History

Does your child:	Yes	No	N/A or Comments
Communicate verbally or by other means of communication (sign, PECS, communication device)?			Indicate which method of communication.
Communicate in full sentences?			
Respond to questions spontaneously?			
Have difficulty speaking clearly so that others understand?			
Have difficulty following muti-step instructions?			
Need additional time to process things that are said to them?			
Rely on visual cues to know how to respond?			

PIN:_____

Gross Motor/Balance/Movement History

Developmental History			
	Independent/ Age Achieved	Needs Assistance/Level of Assistance (dependent, moderate, minimal)	Comments (include use of special equipment)
Rolls over both directions.			
Sits without support			
Crawls on hands and knees			
Walks without support			
Climbs/descends stairs alternating feet			
Rides a riding toy with pedals			
Rides a bicycle without training wheels			
Additional Information			
Does your child:	Yes	No	N/A or Comments
Seem weaker or tires more easily than other children the same age			
Use slow deliberate movements.			
Have difficulty with hopping, jumping, skipping, or running compared to others			
Have difficulty with ball skills (throwing, catching, hitting, kicking, dribbling)			
Appear clumsy, stiff, awkward, have difficulty coordinating both sides of the body, bump into things			
Difficulty using playground equipment			
Confuse right and left sides of the body			
Avoid physical activity/sports; prefers sedentary activities			
Slump, lean on others, furniture or walls			
Has difficulty learning new motor tasks			

PIN:_____

Fine Motor/Visual Motor/Visual Perceptual History

Developmental History			
	Independent/ Age Achieved	Needs Assistance/Level of Assistance (dependent, moderate, minimal)	Comments (include use of special equipment)
Uses a pincer grasp to pick up small items			
Points using index finger			
Holds a writing utensil with thumb and fingers			
Demonstrates hand dominance			Circle one: Right Left
Knows left and right			
Additional Information			
Does your child:	Yes	No	N/A or Comments
Wear glasses?			
Have difficulty cutting with scissors (handling scissors and/or cutting on the line)			
Have difficulty manipulating clothing fasteners			
Have difficulty with tasks that require using both hands together?			
Have difficulty completing age-appropriate puzzles			
Have difficulty drawing or copying simple shapes (circles & lines) & coloring in the lines			
Have difficulty with creative drawing and/or including details in drawings.			
Have difficulty with or avoid constructional activities (blocks, legos)?			
Avoid find motor tasks (writing, drawing, cutting, crafts, self-feeding)			
Reverse letters and/or numbers			
Have difficulty writing on the line or with correct spacing/size			
Complain of hand being tired when writing			
Hold head close to table surface when completing fine motor tasks			
Write or color too dark or too light			
Have difficulty naming or matching colors, shapes or sizes			
Have difficulty tracking a moving object with eyes/unusual eye movements			
Have difficulty locating objects in a distracting background (i.e. cluttered, maps)			

PIN:_____

Self-care History

Developmental History			
	Independent/ Age Achieved	Needs Assistance/Level of Assistance (dependent, moderate, minimal)	Comments (include use of special equipment)
Eats solid foods			
Drinks from an open cup			
Drinks from a straw			
Finger feeds self			
Feeds self using utensils			
Undresses self (shirt, pants, socks, shoes, coat)			
Dresses self (shirt, pants, socks, shoes, coat)			
Manages clothing fasteners (zip, button, snap)			
Opens food containers (bags, storage containers, juice box)			
Dresses self (shirt, pants, socks, shoes, coat, shoe tying) & orients clothing correctly on body			
Bowel/Bladder control (toilet trained)			
Completes basic hygiene routines (hand washing, teeth brushing)			
Additional Information			
Does your child:	Yes	No	N/A or Comments
have difficulty with sleep routines?			
refuse a lot of foods (picky eater, refuses to try new foods)?			What foods are preferred? Avoided?
choke or gag often when eating or drinking?			
Have difficulty knowing when he/she needs to go to the bathroom?			
Have difficulty sensing when he/she is hungry or full?			

PIN:_____

Sensory Processing History

Does your child:	Yes In the past only	Yes Currently	No	N/A or Comments
Does your child avoid being touched by others?				
Startle when touched unexpectedly?				
Avoid getting hands messy/dirty?				
Dislike being barefoot?				
Avoid certain textures (clothing, sheets, blankets, flooring, food)?				
Avoid grooming activities (face/hair washing, brushing hair or teeth, nail cutting)?				
Constantly touch things or other people?				
Have an unusually high or low pain threshold? (circle one)				
Overreact to noises (sirens, vacuum cleaner, fire alarms, etc.)?				
Get easily distracted by background noise?				
Seem to make excessive amount of noise or talk loudly?				
Frequently appear to not hear you when talking to them or have difficulty following directions?				
Frequently rely on visual cues to know what to do or how to respond?				
Avoid activities that challenge balance or lose balance easily?				
Want to be moving constantly (spinning, running, jumping)?				
Get nauseous or fearful when moving through space (car rides, swinging)?				
Avoid or become distressed by bright lights or sunlight?				
Frequently rub or squint eyes or tilt head when looking at something?				
Crave jumping or falling into people or things? Play is often too rough.				
Use too much or too little force when doing things (throwing, writing, jumping)? (circle one)				
Seek lots of hugs and squeezes?				
Seem unaware of how to move their body or frequently run into things?				

PIN:_____

Social-Emotional/Play

Does your child:	Yes	No	N/A or Comments
Engage in creative/pretend play (dress-up, acting out stories)?			
Prefers to play games or with toys that are for younger children?			
Have difficulty initiating play by his/herself or with others?			
Have difficulty expressing emotions or saying how he/she feels?			
Approach tasks or people impulsively?			
Get aggressive with others?			
Have difficulty taking turns or sharing?			
Avoid or become fearful or confused/anxious in social situations?			
Prefer playing alone to playing with others?			
Have difficulty making and/or keeping friends?			
Prefer to play with children who are younger or much older?			

Additional Information

What are your child's strengths?

_____

_____

_____

_____

What are your child's likes?

_____

_____

What are your child's dislikes?

_____

_____

Does your child participate in other programs or activities (i.e. soccer, music lessons, drama classes, etc.)?

What do you find to be most challenging with respect to supporting your child to engage in his/her daily routines?

What are some strategies that have been used (home, school, community) that have been helpful in supporting your child to be successful?

What would you like for your child to accomplish by participating in OT (What are your primary goals)?

Is there any additional information you would like to share about your child?

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