Miss Shannon's Therapy 4 Kidz
2449 N Tenaya Way Unit 34991
Las Vegas, NV 89128
1(702)970-9242
Info@missshannonstherapy4kidz.com

PEDIATRIC OCCUPATIONAL THERAPY INTAKE FORM

Demographic and Family Information

Child's Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ Male ☐ Female ☐
Person completing this questionnaire: _____ *Relationship to child:* _____
Parent/Legal Guardian Names:
Mother: _____ Mother's Age: _____
Mother's occupation: _____ Employer's Name: _____
Mother's phone: _____ work phone: _____ email: _____
Address: _____
_____

In the event that Miss Shannon's Therapy 4 Kidz and/or your therapist must contact you all efforts to maintain confidentially are made. How do you prefer to be contacted?

☐home phone: permission to leave voice message ☐yes ☐no
☐work phone: permission to leave voice message or with individual that answers the phone ☐yes ☐no
☐cell phone: permission to leave voice message ☐yes ☐no: permission to leave text message ☐yes ☐no
☐email; email to: _____
☐written communication ☐mail to address listed above ☐mail to: _____

Father: _____ Father's Age: _____
Father's occupation: _____ Employer's Name: _____
Father's phone: _____ work phone: _____ email: _____
Address: _____
_____

In the event that Miss Shannon's Therapy 4 Kidz and/or your therapist must contact you all efforts to maintain confidentially are made. How do you prefer to be contacted?

☐home phone: permission to leave voice message ☐yes ☐no
☐work phone: permission to leave voice message or with individual that answers the phone ☐yes ☐no
☐cell phone: permission to leave voice message ☐yes ☐no: permission to leave text message ☐yes ☐no
☐email; email to: _____
☐written communication ☐mail to address listed above ☐mail to: _____

Child lives with:
☐ both parents ☐ mother ☐father ☐ shared (part-time at each home) ☐ legal guardian ☐foster home
☐other:_____
If child is in foster care, when was first placement? _____ What placement are you? _____

Any other information: _____

Any other agencies involved in this case? _____

Language(s) spoken in the home: _____

Others living in the household: _____

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Physicians

Pediatrician Name: _____

Office: _____

Phone: _____

Address: _____

Physician referral from: _____

Doctor: _____

Office: _____

Phone: _____

Address: _____

Date of last visit/check-up with pediatrician/physician/specialist: _____

Insurance

Primary Insurance Company: _____ Insurance Company Phone: _____

Subscriber's Last Name: _____ First Name: _____

Subscriber's ID#: _____ Subscriber's Date of Birth: _____

Coverage Effective Date: _____

Group Number: _____Policy Number: _____

Client Relationship to Subscriber: _____

Secondary Insurance Company: _____ Insurance Company Phone: _____

Subscriber's Last Name: _____ First Name: _____

Subscriber's ID#: _____ Subscriber's Date of Birth: _____

Coverage Effective Date: _____

Group Number: _____Policy Number: _____

Client Relationship to Subscriber: _____

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Areas of Concern/Goals

When did you first have concerns about your child? _____

_____

What made you concerned? _____

_____

What strategies or techniques have you been trying independently? _____

_____

What are your child's strengths? _____

_____

What are your primary areas of concern/ what are you hoping for the therapist to address? (i.e. academic, sensory, motor, play, ADLs (eating, dressing)). _____

_____

What are your goals for occupational therapy?

_____

_____

What specific skills would you like your child to achieve in therapy? _____

_____

Has your child received previous therapies? _____

If so what type and when was last date of services: _____

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Medical History

Birth History: Pregnancy- How many weeks? _____ Singleton ☐ Twin A ☐ Twin B ☐

Hospital: _____ Weight: _____ How many weeks gestation: _____

Any difficulties during pregnancy? (medical/health, stress, drugs/alcohol, mental health, bed rest, gestational diabetes, other):_____

_____

☐None

List any medications and/or substances taken during pregnancy and their purpose: _____

_____

☐ None

Any difficulties during labor? (C-section, forceps, low weight, preeclampsia/toxemia, other):_____

_____

☐None

Any difficulties following delivery? _____

☐None, went home with mother.

☐Respiratory Difficulties

☐Ventilator Required-duration_____

☐Oxygen Support-duration_____

☐NICU Stay-duration_____

☐Reflux

☐Feeding Difficulties-describe_____

☐Intra Uterine Growth Restriction (IUGR)

☐Other-Please Describe_____

Concerns with early development? (colic, growth, chronic ear infections, torticollis, frequent fevers)?

_____

_____

_____

☐None

Medical/Surgical History: List significant past or current medical conditions of child (i.e. illnesses, hospitalizations, surgeries, genetic conditions):

_____

_____

☐None

Please check any of the following if they apply to your child:

☐Abnormal Lab Results

☐Abnormal Muscle Tone

☐Allergies

☐Asthma

☐Bronchitis

☐Cardiac Issues

☐Chicken Pox

☐Chronic Ear Infections

☐Colic

☐Constipation

☐Compromised Immune System

☐Ear Tubes

☐Frequent Antibiotic Use

☐Frequent Fevers

☐GERD/Reflux

☐Head Injury

☐Hydrocephaly

☐Lyme Disease

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☐Measles ☐Mumps ☐Plagiocephaly

☐Poor Sleep ☐Poor Weight Gain ☐Pneumonia

☐Respiratory Issues ☐Seizures

☐Surgeries: List Above ☐Tonsils/Adenoids ☐Trauma

☐Torticollis ☐Other_____

When was your child's last hearing checkup? _____ Where: _____

Results: _____

Does your child require a hearing device? Yes ☐ No ☐ If yes, describe: _____

Does your child have PE tubes? Yes ☐ No ☐ Date placed: _____

When was your child's last vision check up? _____ Where: _____

Results: _____

Does your child require glasses? Yes ☐ No ☐ If yes, describe: _____

List any medications currently taken by your child and their purpose (include prescription drugs, over the counter meds, vitamins, and homeopathic medications):

_____

_____

Does your child have any allergies? ☐Yes ☐No If yes, please list: _____

_____

Is your child on a specific diet or food restrictions? ☐Yes ☐No

If yes, please list: _____

_____

Does your child have regular sleeping habits or good ability to fall asleep and stay asleep? ☐Yes ☐No

If no, please describe: _____

_____

Does your child have a history of frequent ear infections? ☐Yes ☐No Age Started: _____

If yes, how many infections did he/she have in the past year? _____

What (if any) special equipment does your child use?

☐Wheelchair ☐ Braces/Orthotics ☐Walker ☐Crutches ☐Communication Device-type_____

☐Other: _____

Medical Precautions: _____

Has your child received regular immunizations? _____

Please check if there is any known history of the following in the immediate or extended family:

☐Autism ☐ADD/ADHD ☐Anxiety ☐Learning Disabilities ☐Mental Illness ☐PDD

☐Hearing Loss ☐Speech/Language Delays ☐Other: _____

List the names of the programs/people that work with your child outside of Miss Shannon's Therapy 4 Kidz.

Service	School/Practice Name	Provider Name	Last Seen On
ABA/Behavior Specialist			

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Audiologist			
Cardiologist			
Casework/Care Coordinator			
Childcare/Daycare			
Counselor			
Child Protective Services			
Dietician/Nutritionist			
Early Childhood			
Early Intervention			
ENT			
Gastroenterologist			
Learning Specialist			
Music Therapy			
Neurologist			
Neuropsychologist			
Occupational Therapy			
Orthopedic			
Pediatrician/Physician			
Physical Therapist			
Preschool			
Psychiatrist/Psychologist			
School OT, PT, ST			
Speech Therapist			
Specialist			
Other			
Other			

Please feel free to provide us with a copy of your child's IFSP or IEP so that we can better serve you and your child. If you have outside testing reports (i.e. neuropsychological testing, developmental pediatrician testing, etc) please provide a copy to us for your child's record.

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all of medical information by any means of communication to Miss Shannon's Therapy 4 Kidz.

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_____ Signature of Patient or Responsible Party _____Date

_____Patient Name _____ DOB _____Relationship to Patient

Upcoming evaluations scheduled, if applicable: _____

_____

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Developmental History

How would you describe your child's activity level as an infant? _____

_____

How would you describe your child's sleep patterns as an infant? _____

_____

Was your child difficult to console as an infant when agitated? _____

_____

Milestone	Age Achieved	Not Yet Achieved	Comment
Rolling belly to/from back			
Sitting alone			
Crawling on hands/knees			
Standing alone			
Walking alone			
Finger feeding			
Chewing solids			
Scribbling			
Babbling			
Toilet trained			☐Dry Day ☐Dry Night

Comments: _____

If there was anything unusual you noticed in any of the above developmental milestones, please explain:

_____

_____

Motor Skills: My child:

☐Yes ☐No Appears clumsy or uncoordinated ☐Yes ☐No Fatigues easily and has poor endurance

☐Yes ☐No Is frequently slouched/slumped, uses hand to hold up head, prefers to lean against, etc

☐Yes ☐No Bumps into people or objects while walking ☐Yes ☐No Falls easily and/or often

☐Yes ☐No Trips over own feet ☐Yes ☐No Appears weak

☐Yes ☐No Seems fearful of movement ☐Yes ☐No Jumps with both feet of the ground

☐Yes ☐No Has difficulty moving his/her body on playground equipment

☐Yes ☐No Walks on his/her toes ☐Yes ☐No Has difficulty pedaling a bike

☐Yes ☐No Is able to balance on one foot

☐Yes ☐No Has difficulty performing reciprocal movement pattern (i.e. alternating legs when climbing stairs)

☐Yes ☐No Has a hand preference ☐Right ☐Left ☐Yes ☐No Has difficulty using scissors

☐Yes ☐No Has difficulty grasping/managing small objects

☐Yes ☐No Has difficulty grasping a crayon/pencil/marker ☐Yes ☐No Has difficulties with handwriting

☐Yes ☐No Writes at a slower pace than his/her peers ☐Yes ☐No Can write on the writing line

☐Yes ☐No Has difficulty spacing letters and words when writing

☐Yes ☐No *writes* with faint/light lines-cannot be read

☐Yes ☐No *Writes* with dark/bold lines-rips paper/pushes pencil/pen through paper

☐Yes ☐No Has difficulty mixing up upper and lower case letters when writing

☐Yes ☐No Is unable to use cursive, continues to print

☐Yes ☐No *Draws* with faint/light lines ☐Yes ☐No *Draws* with dark/bold lines

☐Yes ☐No Creates drawings with recognizable parts

☐Yes ☐No can hold his/her paper with one hand and color with the other

☐Yes ☐No Can use both hands together in a task (i.e. string beads, manipulate a zipper)

☐Yes ☐No Has difficulty putting together Legos, Block Designs, or Puzzles

☐Yes ☐No Watches others for visual cues when performing the same task

☐Yes ☐No Can identifying whether objects are placed in the background or foreground (i.e. finding a certain object in a crowded drawer, seeing "hidden pictures" in books)

☐Yes ☐No Can track a moving object with his or her eyes (i.e. before catching a ball)

☐Yes ☐No Unaware of being touched or bumped unless done with extreme force

☐Yes ☐No Unaware of that face or hands are dirty (i.e., nose running, food on face)

☐Yes ☐No Is in constant motion/ "on the go" ☐Yes ☐No Has difficulty sitting still

☐Yes ☐No Chews on pens, straws, shirts, etc ☐Yes ☐No Frequently touches people and objects

☐Yes ☐No Frequently gets in everyone else's space ☐Yes ☐No Agitated by loud/unexpected noises

☐Yes ☐No Is extreme sensitive to sensory experiences (i.e. sounds, touch, lights, smells); fight/flight responses. If yes, please explain: _____

☐Yes ☐No Avoids touching certain textures. If yes, please list: _____

☐Yes ☐No Avoids messy play (i.e. finger paints, play dough, mud, sand)

☐Yes ☐No Is sensitive to clothing tags or textures ☐Yes ☐No Complains about having hair brushed

☐Yes ☐No Resists having teeth brushed/oral care ☐Yes ☐No Resists trimming/clipping of nails

☐Yes ☐No Resists washing/cutting of hair ☐Yes ☐No Refuses to walk barefoot

☐Yes ☐No Takes longer to react/not react to sensory experiences (i.e. appears to be in his/her own world, does not respond to his/her name when called)? If yes, please describe: _____

_____

☐Yes ☐No Seems to actively search/seek/crave sensory experiences (i.e. constant pushing, pulling, hanging off, jumping, spinning; constantly on the move; seems unable to stop talking; fidgeting with hands, touching people to the point of irritating others); under responsive. If yes, please describe: _____

_____

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☐Yes ☐No Has difficulty distinguishing sensory experiences (i.e. trouble distinguishing objects in pockets, trouble recognizing objects by their shape, trouble differentiating smells). If yes, please describe:

_____

_____

☐Yes ☐No Gets "stuck" on toy or task, has difficulty changing to another task; hyper focus on activities/objects

☐Yes ☐No Is fearful on swings ☐Yes ☐No Is fearful of slide/other playground structures (climbing/movement)

☐Yes ☐No Is fearless on playground equipment

Will use: ☐Swings ☐Slides ☐Ladder ☐Climbing Net ☐Bridges ☐Sandboxes ☐Monkey Bars

Becomes upset by: ☐Fireworks ☐Motorcycles ☐Horns ☐Vacuums ☐Alarms ☐Bells ☐Unexpected Noises

☐Yes ☐No Has difficulties learning new motor skills- problems planning and carrying out new actions, difficulty forming a goal or idea or developing new motor skills.

Comments: _____

_____

Activities of Daily Living (Routine Activities)

	Independent	Parents assist with set up of materials only	Verbal Assistance	Physical Assistance How Much	Dependent
Taking off shoes					
Putting on shoes					
Taking off socks					
Putting on socks					
Taking off clothes					
Putting on clothes					
Fasteners-snaps					
Fasteners-buttons					
Fasteners-zippers					
Fasteners-buckles					
Fasteners-tying shoelaces					
Bathing-washing body					
Bathing-washing hair					
Grooming-brushing hair					
Grooming-tolerance to getting hair cut					
Grooming-brushing teeth					
Grooming-tolerance to clipping of nails					
Feeding-finger foods					
Feeding-use of					

utensils-spoon					
Feeding-use of utensils-fork					
Feeding-use of cup-closed					
Feeding-use of cup-open					
Feeding-use of straw					
Washing hands					
Wiping face					
Opening of containers					
Toileting					

Comments:

_____

_____

_____

Meal Time: Avoids these textures:

☐None, tolerates all textures ☐Puree ☐Crunchy ☐Mashed ☐Mixed

Comments: _____

Avoids these flavors:

☐None, tolerates all flavors ☐Salty ☐Sweet ☐Sour ☐Spicy ☐Bland

Comments: _____

Avoids these food groups:

☐None, tolerates all food groups ☐Dairy ☐Fruit ☐Grains ☐Meats ☐Vegetables

Comments: _____

Olfactory System: Does your child have sensitivities to smells, if so please list:

_____

Bedtime: Does your child have a difficult time falling asleep? ☐Yes ☐ No

If so how long does it take him/her to do so? _____

Does your child sleep through the night? ☐Yes ☐ No How many hours? _____

Does your child nap during the day? ☐Yes ☐No How many hours? _____

Do you have a family bed? ☐Yes ☐No

If No, is your child able to sleep in their own bed/sleep alone? ☐Yes ☐No

Comments: _____

Behavior, Play, and Social-Emotional

Emotional concerns: (fears, anxiety, nightmares, poor self-esteem) _____

_____

_____

Behavioral concerns: (distractibility, impulsive, repetitive behaviors, tantrums, aggressive/destructive, nervous habits, defiant) _____

_____

_____

My child is able to:

☐Yes ☐No Respond to the feeling of others by acknowledgement or showing support

☐Yes ☐No Control anger towards others and reduce aggressive acts

☐Yes ☐No Recover from a hurt or disappointment without lashing out at others

☐Yes ☐No Display emotions that are appropriate for the situation

☐Yes ☐No Persist in a task despite frustration

☐Yes ☐No Utilize relaxation strategies to cope with stressful events

My child:

☐Yes ☐No Is easily frustrated ☐Yes ☐Has difficulty calming down

☐Yes ☐No Has difficulty following rules/following directions ☐Yes ☐Has a poor attention span

☐Yes ☐No requires more time than other children to process verbal information (i.e. takes additional time to comprehend and respond to questions)

☐Yes ☐No Does better when following a structured routine

☐Yes ☐No Struggles/upset with changes in routine, if yes please explain_____

☐Yes ☐No Frequently modifies/interchanges activities so that they are of interest to him/her

☐Yes ☐No Has episodes of uncontrolled behavior

☐Yes ☐No Struggles to have organization (i.e. having an uncluttered workspace, finding/putting away materials neatly in a backpack) ☐Yes ☐No Requires gratification "right now" when asking for something

☐Yes ☐No Cries Often ☐Yes ☐No Frequent temper tantrums, if yes, how often_____

☐Yes ☐No has poor frustration tolerance ☐Yes ☐No has poor safety awareness in the community

☐Yes ☐No has difficulty calming and/or coping with anger if upset/angry ☐Yes ☐No Anxious

☐Yes ☐No Avoids touch with others ☐Yes ☐No Rocks self to sound

☐Yes ☐No Mouths objects ☐Yes ☐Engages in risky play activities ☐Yes ☐Prefers rough play

List any other significant issues that may help us understand your child better (medical, social, behavior, fears, phobias, academic difficulties, issues with transitions, etc.)

_____

_____

How do you handle discipline issues at home? _____

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_____

How does your child express him/herself? _____

_____

_____

What are your child's interests at home? (e.g., sports, hobbies)

_____

_____

_____

What things about your child do you enjoy?

_____

_____

Describe how your child interacts with siblings or other children._____

_____

Describe the play activities in which your child engages. _____

_____

_____

How much screen time does your child get (i.e., tablets, smart phones, computer, TV, etc.)? _____

_____

What games, activities, and toys does your child enjoy?

_____

_____

Describe how your child interacts with other children: _____

_____

My child:

☐ prefers to play alone ☐ prefers to play with 1 or 2 others ☐ plays mostly with siblings

☐plays mostly with adults ☐ has a lot of friends ☐has difficulty making and keeping friends

☐has difficulty taking turns when playing with peers ☐attempts to control social situations

☐is able to carry on a conversation with peers and/or adults

☐is able tolerate group situations (i.e. playing with others on playground, working together with classmates in classroom) ☐ is able to play with age appropriate toys

☐ responds when his/her name is called ☐is able to pay attention as well as most other children his/her age

Do you have concerns about your child's ability to play with other children? ☐Yes ☐No If yes, please describe:

_____

Briefly describe a typical day for your family, especially this child (feel free to use the back of this paper, if needed):_____

_____

_____

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Education

Did/Does your child require early intervention services? Yes ☐ No ☐

Where does your child attend school/grade? (Indicate private, public, inclusion, self-contained):_____ Grade/Level _____

If not school age, other group experience? _____

Daycare: _____

What does the child/teacher report as your child's likes and dislikes at school?

_____

_____

Barriers to Learning: ☐Blind ☐Deaf ☐Cognitively Impaired ☐Language

☐Emotional/Anxiety ☐Other (specify):_____

Does your child have an IFSP; IEP; or 504 Plan? _____

Anything else you want us to know about your child? _____

_____

_____

_____

Thank You for taking the time to complete this questionnaire.

It assists us in better understanding your child and your family.

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