modern OT
occupational therapy services

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info@modernOT.ca

PEDIATRIC OCCUPATIONAL THERAPY INTAKE FORM

We ask that you fill in this form and return it to us prior to your child's appointment. This form can be returned to our main office via email at **info@modernOT.ca** or by fax at **613-792-3462**.

The information on the form allows the occupational therapist to tailor the assessment activities to your child, prior to your appointment. Upon review of the form, the occupational therapist will contact you to book the assessment session. The assessment takes approximately 2 hours. We typically complete these assessments in the clinic, either in our main clinic in Ottawa, or our satellite community clinics (Pembroke and Kingston). We can also complete the assessment in your home; however, there is an additional fee for the therapist's travel time.

Once the therapist has completed scoring and analysis of the outcome, she will provide a review of the results and recommendations with you, both verbally and in a written report.

The total cost for assessment is $480.00, which includes the parent intake, the assessment itself, and the report.

Child Information			
Name		D.O.B.	
Address		Age	
		Gender	
School name		Grade	
Resides with			

Parent/Guardian Information					
Guardian 1				Relationship	
Email					
Please check if it is ok to leave a message				Yes	No
Home Phone					
Cell Phone					
Work Phone					
Preferred method of communication:		Home ph.	Cell ph.	Work ph.	Email
Guardian 2				Relationship	
Email					

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(Guardian 2 cont...) Please check if it is ok to leave a message				Yes	No
Home Phone					
Cell Phone					
Work Phone					
Preferred method of communication:		Home ph.	Cell ph.	Work ph.	Email

Primary areas of concern / What are you hoping the Occupational Therapist to address?

Prenatal / Birth History							
Please place a check mark by any complications experienced during pregnancy							
Diabetes		Measles		Toxemia		Strep	
Drug Use		Alcohol Use		Pre- Eclampsia			
Please place a check mark by any labour and delivery complications experienced							
C – Section		Vacuum		Forceps		Other	
Premature		Low weight		IUGR		NICU Stay	
Comments							

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Medical History							
Diagnoses							
Please place a check mark by any conditions / illnesses your child has experienced							
Chicken pox		Mumps		Pneumonia		Tonsillitis	
Bronchitis		Reflux		Allergies		Head injury	
Ear infections		Seizures		Measles		Asthma	
Cardiac issues		Poor sleep		Torticollis		Colic	
Please place a check mark by any current therapies/interventions your child is receiving							
Psychologist		SLP		PT		Medical	
Hospitalization(s)		Length		Reason			
Surgeries		Age		Type			
Evaluation or Testing		Age		Type			
Medical History Comments							

Developmental History							
Please note when each of the following occurred							
Sat (no support)		Rolled over		Crawled		Stood	
Walked		Talked		Dressed (self)		Fed (self)	
Toilet trained							
Do you have any motor development concerns? (walking up/down stairs, running smoothly, stacking blocks, drawing, cutting, writing, etc.)							

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Hearing and Vision				
	Yes	No		
Has your child ever have a vision test?			Results	
Does your child wear glasses?			Near or far?	
Has your child ever had a hearing test?			Results	
Does your child wear a hearing aid?			Left or right?	
Comments				

Behaviour and Social Skills					
Please indicate if any statements describe your child					
	Yes	No		Yes	No
Follow verbal directions			Takes turns with peers		
Initiates Conversation			Displays aggression		
Makes eye contact			Prefers to play alone		
Has safety awareness			Has tantrums		
Impulsive/ takes risks			Extremely sensitive		
Pays attention			Unable to self-calm		
Listens well			Does not like crowds		
Plays well with others			Does well with change		
Comments					

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Sensory Status		
Please indicate if any statements describe your child	Yes	No
Tolerates self-care activities (bathing, tooth brushing, hair brushing)		
Appears clumsy/awkward (trips, bumps into other people or objects, trouble coordinating body parts)		
Has a fear of using playground equipment (swinging, feet leaving the ground, heights or head being upside down)		
Is constantly moving/seeks certain types of movement		
Has difficulty keeping hands to him/herself (touching others or touching materials/objects)		
Avoids messy play/doesn't like when hands get dirty		
Appears overly sensitive to certain textures, smells, noises.		
Chews on non-edible objects/puts them in his/her mouth		
Often invades others personal space		
Is unaware of being touched or bumped unless with extreme force and does not notice when face or hands are dirty		
Comments		

Daily Routine and Family Information		
Sleep		
What time does the child go to bed?	Week:	Weekend:
Does the child have difficulty falling asleep?		
Does the child wake during the night?		
Does the child have difficulty waking?		
Does the child tend to wake refreshed?		

What are your child's favorite toys/activities?

Do you feel your child gets enough to eat and has a balanced diet?

What family members does the child share the home with?

What is the primary language spoken at home? Any additional languages spoken?

Are there any strategies currently in place at school to assist your child? (e.g., computer use, sitting at the front of class, additional time to complete work, educational assistant, etc.)

Is there any known history of the following in the immediate or extended family?

	Yes	No		Yes	No
Autism/ PDD			ADHD		
Learning disabilities			Speech Language Delays		
Hearing Loss			Stuttering		

Thank you for taking the time to fill in this form!