**The Firefly Center: Therapy Services for Children**
**www.fireflycenter.com**
**(415) 533-0324**

# OCCUPATIONAL THERAPY INTAKE QUESTIONAIRE

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Home Address: _____

_____

Additional Address (if applicable): _____

_____

Home Phone Number: _____ Work Number: _____

Cell Phone Number: _____ Fax Number: _____

E-mail Address: _____

**•FAMILY HISTORY•**

• Parent(s) Names and Occupations: _____

• Step or Foster Parent(s) Names and Contact Number(s): _____

_____

• Members of your household: _____

_____

• If your child lives at more than one home, please indicate living arrangements: _____

_____

• Sibling(s) Names and Ages: _____

• Pet(s) Names and Type: _____

**•MEDICAL AND HEALTH INFORMATION/HISTORY•**

Pediatrician Name: _____

Address: _____

Phone Number: _____

Other Health Professional(s):

Name/Title: _____

Phone number: _____

Check below all that apply and note details:

• Does your child wear:

☐ Glasses ☐ Hearing Aids ☐ Orthotics (note type) ☐ Prosthetics

• Is your child: ☐ Left Handed ☐ Right Handed ☐ Not yet decided

• Complications or difficulties during pregnancy: _____

_____

• Complications during or after birth (note caesarian section, forceps use, atypical presentation, low APGARs, etc.): _____

_____

• Birth weight (note if premature, how early, and any complications): _____

_____

• List/describe any early childhood health problems or illnesses: _____

_____

• Note any surgeries, hospital stays or medical procedures: _____

_____

• List/describe any current health issues (including but not limited to seizures, ear infections, asthma, respiratory infections, PE tubes, GI difficulties, etc.): _____

_____

_____

• List current medications including name of medication, dosage and reason for administration:

_____

• List any supplements or dietary programs currently in use: _____

_____

• List any allergies: _____

• Describe any difficulty with sleep, or atypical sleep patterns: _____

_____

• Describe any difficulty with eating and any food preferences/avoidances (taste or texture): _____

_____

**•DEVELOPMENTAL HISTORY•**

• Age when your child first sat up: _____

• Age when your child first crawled: _____

• Age when your child first walked: _____

• Age when your child began speaking: _____

**•FUNCTIONAL STATUS•**

Describe any difficulties in the following areas. Please note if your child is "independent".

• Eating with a utensil: _____

• Drinking from a regular cup (note if sippy cup used): _____

_____

• Managing mealtime containers (i.e. Tupperware, juice box, zip lock baggies, thermos, etc.):

_____

• Dressing (note difficulty with putting clothes on, taking them off, fasteners, shoe tying, left/right confusion, etc.): _____

_____

• Toileting/toilet training: _____

• Note any concerns about your child's speech and language development: _____

_____

• Note any concerns about your child's social development/friendship skills: _____

_____

• Note any behavioral concerns: _____

_____

• Note any sensory concerns (a separate sensorimotor history will also be provided): _____

_____

**•SCHOOL INFORMATION•**

Current School: _____

Address: _____

Grade: _____

Teacher or Contact Person and Phone Number: _____

Note any difficulties or areas of need your child's teacher has mentioned:

Describe any current academic or school concerns:

**•HISTORY OF SERVICES•**

List any therapeutic or educational evaluations or services your child receives/has received. Note frequency/duration of services and contact information. Provide copies of any pertinent assessments.

**•AREAS OF CONCERN•**

Describe areas of concern regarding your child's development and/or status (i.e. gross/fine motor skills, daily living skills, self care skills, visual motor skills, sensory processing, etc.).

**•ADDITIONAL COMMENTS/INFORMATION•**

Thank you for completing this Questionnaire-- your time and effort are appreciated!
Please notify your child's OT of any other necessary information not relayed on this form.
We look forward to working with you and your child.

| EMERGENCY CONTACT INFORMATION |
| --- |
| **NAME:** |
| **PHONE NUMBER:** |
| **SPECIAL INSTRUCTIONS/INFORMATION:** |