sweet pea OT PEDIATRIC OCCUPATIONAL THERAPY

Intake Form

Name of Child _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Parent/Guardian

First Name _____ Last Name _____

First Name _____ Last Name _____

Contact Info

Home Phone _____ Work Phone _____ Cell Phone _____

Primary E-mail _____ Secondary E-mail _____

Additional Info

Primary language spoken in the home _____

Name and age of Siblings

Who referred you and what is the reason for referral

Pediatricians Name _____

Pediatricians Contact Information

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Intake Form Continued

Have you had an OT evaluation? ☐ Yes ☐ No

If yes, please give the date and name of OT practice

Have you had OT treatment in the past? ☐ Yes ☐ No

If yes, why and please briefly describe your experience.

Has your child ever been hospitalized? ☐ Yes ☐ No

If so, when and why?

Does your child have any allergies? ☐ Yes ☐ No

If yes, what?

Is your child taking any medication? ☐ Yes ☐ No

If yes, what?

Does your child have a current diagnosis? ☐ Yes ☐ No

Are there any associated precautions?