Dear Parent or Guardian,

My name is Mindy Hoholik and I am the Occupational Therapist who will be evaluating your child. I look forward to providing services that will help your child aquire skills and knowledge that will facilitate his/her increased independence with completing daily activities. Please complete the following questionnaire, as well as the **Sensory Profile,** so that I may gather necessary information about your child to determinte the most appropriate goals and to address any concerns that you may have regarding your child's development.

Sincerely,

Mindy Hoholik, MS, OTR/L

Intake Form for Pediatric Patients

Name of Child: _____ Date of Birth: _____

Name of Parent(s) or Guardian(s) with whom child lives: _____

_____

Primary caregiver for child: _____

Number of siblings and ages: _____

_____

Language(s) spoken in the home: _____

Do you live in a house or apartment: _____ Number of floors: _____

MOTHER'S PREGNANCY (for this child only)

Did you have any problems during pregnancy? _____ If yes, please explain: _____

_____

Was the birth full-term or premature? _____ If premature, what month? _____

Birth Weight: _____lbs. _____oz.

Did you or the baby have any problems before, during, or after birth? _____ If yes, please

explain: _____

DEVELOPMENTAL HISTORY

At what age did your child first:

Sit Alone:	_____	Feed self with spoon/fork:	_____
Crawl:	_____	Speak first word:	_____
Stand alone:	_____	Speak first sentence:	_____
Walk:	_____	Become toilet trained:	_____

Does your child sleep through the night? _____ How many hours per night? _____

Any naps during the day? _____

MEDICAL HISTORY

Date of last medical checkup: _____ Height: _____ Weight:_____

Has your child been hospitalized? _____ If so, when? _____

For what reason? _____

Has s/he had any operations/surgeries? _____ If yes, please explain: _____

_____

Does your child have **seizures**? _____

Has your child had any major illnesses? _____

Does your child take daily medications? _____ If yes, please provide name, dosage, and reason for taking: _____

Is your child allergic to any foods or medications? (please list all): _____

_____

Does your child have a specialized or restricted diet? _____

Any problems during mealtime or concerns with eating? _____

_____

Was your child ever diagnosed with Autism Spectrum Disorder? _____

Has your child had an Early Steps and/or FDLRS evaluation? _____

CURRENT FUNCTIONING

Please circle YES or NO for the following tasks based on your child's **CURRENT abilities.*

FEEDING/EATING

Feeds self with fingers	YES	NO
Feeds self with a spoon (no spilling)	YES	NO
Picks up and drinks from an open-top cup	YES	NO
Chews well	YES	NO
Discriminates edibles from non-edibles	YES	NO
Sucks through a straw	YES	NO
Begins to use fork and knife	YES	NO
Spreads soft foods with a table knife	YES	NO
Unwraps/opens food packages	YES	NO
Gets self drink including pouring	YES	NO
Serves self food or snack independently	YES	NO

TOILETING

Indicates need to toilet	YES	NO
Remains dry between regular toileting	YES	NO
Has regular bowel movements	YES	NO

Remains dry through the night	YES	NO
Toilets independently except for wiping	YES	NO
Manages clothing before & after toileting	YES	NO
Wipes after toileting independently	YES	NO

DRESSING

Pulls off hat, socks, or mittens on request	YES	NO
Cooperates in diapering and dressing by moving limbs	YES	NO
Undresses completely except for fasteners	YES	NO
Distinguishes front from back of clothing	YES	NO
Unzips and zips large zipper (already hooked by adult)	YES	NO
Hooks zipper independently	YES	NO
Puts on/removes pullover shirt independently	YES	NO
Puts on socks and slip on shoes independently	YES	NO
Fastens/unfastens snaps or buttons of pants	YES	NO
Laces and ties shoes independently	YES	NO
Dresses self except for difficult fasteners	YES	NO

HYGIENE/GROOMING

Attempts to brush hair	YES	NO
Brushes/combs own hair	YES	NO
Wipes/washes own face	YES	NO
Cooperates with tooth brushing	YES	NO
Brushes teeth independently	YES	NO
Blows and wipes nose on request	YES	NO
Covers mouth when coughing	YES	NO
Applies antiperspirant independently	YES	NO
Bathes self with supervision	YES	NO
Turns water faucet on/off	YES	NO
Obtains soap and paper towel	YES	NO
Washes & dries hands independently	YES	NO

ABOUT YOUR CHILD

Does your child attend a school program? _____ If yes, where? _____

_____ Grade level: _____

Does your child receive any special services at school? If yes, please describe: _____

_____

Has your child received occupational therapy in the past? If yes, for how long: _____

_____

How do you feel your child learns best? _____

Can your child separate easily from you? _____

What are your child's strengths? _____

And weaknesses/challenges? _____

What is your child's favorite activity at home? _____

How long is s/he able to attend to one activity? _____

How does your child do with interacting with other adults? _____

With other children? _____

Does s/he have any chores (please list all)? _____

_____

Do you feel your child has any behavioral/emotional problems? _____ If yes, please describe:

_____

Can your child become physically aggressive (in the form of hitting, biting, scratching, or other injurious behaviors) to self or others? _____ If yes, please explain: _____

_____

Are there any problems or concerns not mentioned previously, that you feel should be shared?

_____

_____

Are you able to bring your child to therapy up to 3 times per week? _____

IMPORTANT: Please list any goals you have for you child: _____

_____

This questionnaire was completed by: _____

Signature: _____ Date: _____

Thank you for your time completing this questionnaire.