OT KIDS
I can!

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THERAPY INTAKE FORM

OT Kids requests the following information for the purpose of completing a thorough evaluation of your child. Depending on your child's abilities, some questions may not be applicable.

General Information:

________________________________ / / ____________________

Patient's name D.O.B. Age Gender

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Person providing information Date

Has you child even been diagnosed with any of the following:

- ◯ Autism / PDD
- ◯ ADHD
- ◯ Sensory Processing Disorder
- ◯ Speech / Language Delays
- ◯ Learning Disabilities
- ◯ Other

If yes, when were they diagnosed and by whom?

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Concerns:

1. Who referred you to OT Kids and why?

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2. When were you first concerned about your child and what made you concerned?

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3. What is your main concern at the moment?

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

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5. Has your child received any form of therapy previously? If yes, please provide details of the Healthcare Professional.

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Pregnancy and Birth History:

1. Were there any illnesses or other complication during pregnancy?

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2. Was the pregnancy full tern? If not, please provide gestational age.

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3. Was the labor and delivery normal? What was the method of delivery?

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4. Was oxygen or respiratory assistance required after birth?

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Developmental History:

1. At what age did your child roll over, sit, crawl, stand and walk?

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2. Did you notice any significant delays or areas of concern whilst your child developed?

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3. Is there a history of school- or learning difficulties in the family?

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Medical History:

1. Is your child currently taking any medication, including supplements and vitamins? If yes, please list.

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2. Does your child suffer from any allergies, illnesses or diseases?

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3. Has your child ever been hospitalized? If yes, why and for how long?

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4. Have all immunizations been administered? Yes / No

5. When last did your child have their eyes and ears tested?

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Play and Social Skills:

1. Does your child engage in eye contact during communication? Yes / No / Sometimes
2. When given a choice, does your child prefer to play alone or with others?

3. How does your child interact with parents / caregivers, as well as others (shy, aggressive, cooperative, etc.)?

4. Who lives with the child? Please include all siblings and ages.

5. Who is at home with the child in the afternoon or does the child attend full day aftercare?

6. What are some of your child's favourite toys or interests?

Sensorimotor History:

1. Describe your child's general behaviour

2. Describe your child's ability to follow instructions

3. Describe your child's response to discipline. What method of discipline is being used at home?

Education:

1.Does your child attend school? If yes, where and how often?

2. What grade is your child presently in?

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3. Please list any services your child receives at school (Speech Therapy, Monkeynastix, etc.)

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4. Does your child experience any specific challenges in school?

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Thank you so much for taking the time to provide us with the above information. In order to benefit your child optimally, it is sometimes necessary to collaborate with other Healthcare Professionals and your child's educators. According to the rules and regulations set out by the Health Professions Council of South Africa, permission must be granted by the parent / legal guardian of a minor in order for us to share this information.

I hereby grant OT Kids to release and / or obtain information about the above patient from relevant Healthcare Professionals as well as educators.

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Parent / Legal Guardian Name | Signature | ID Number