COMMUNITY AUTISM SERVICES
THE STEPPING STONES GROUP

Occupational Therapy Intake Form

What are your primary concerns/goals for occupational therapy regarding your child?

What are your child's strengths?

What are some of your child's favorite things? Favorite play activities? Please, list any favorite characters, such as super heroes or cartoon characters, or any types of favorite song artists, as applicable.

What makes your child happiest?

Hand preference: Right Left Both Unknown

Does your child receive special instruction or have an established IEP? no yes

Or 504 Accommodation Plan no yes

School based therapy? OT PT Speech and Language

Medical History

Remarkable Diagnoses:

_____

Known food allergies:

_____

Special Diet (Gluten free, pureed food only, tube feeding, etc.):

_____

Medical precautions:

_____

Currently receiving services from other health care professionals:

Psychologist PT Speech and Language Nutritionist Behavioral Specialist Other:

Developmental History

Please check all the developmental milestones that your child achieved:

rolling sitting alone creeping on all 4's pull to stand walking

eating with a spoon hopping on one foot finger feeding

cutting with a knife cutting with scissors jumping riding a bike

Developmental milestones were met: within typical age ranges delayed

Areas of special concern regarding developmental milestones:

Please check the amount of assistance needed for your child to complete the following:

	No Help Needed	Only Needs Supervision	Needs 25% Help	Needs 50% Help	Needs 75% Help	Needs 100% Help
Feeding						
Using Spoon						
Using Fork						
Using Knife						
Puncturing straw in drink						
Grooming						
Brushing Teeth						
Bathing						
Upper Dressing						
Lower Dressing						
Snaps						
Shoes on						
Shoes off						
Tying shoes						
Socks on						
Socks off						
Toileting						

Other concerns:

Please check if you would describe the following as remarkable for your child:

	Yes	No	Sometimes	Not Applicable
Mostly quiet				
Overly active				
Tires easily				
Talks constantly				
Too impulsive				
Restless				
Clumsy				
Nervous ticks/habits				
If applicable, describe:				
Wets bed				
Poor attention				
	Yes	No	Sometimes	Not Applicable
Frustrated easily				
Unusual fears				
Rocks self frequently				
Mostly quiet				
Stubborn				
Resistant to change				
Fights frequently				
Usually happy				
Exhibits temper tantrums				
Difficulty falling asleep				
Difficulty staying asleep				
Sluggish in the mornings				

Social and Occupational History

Please check how you would describe the following for your child:

	Often	Sometimes	Rarely	Not Applicable
Socialize with family and close friends?				
Communicate needs and wants effectively?				
Hard to make friends?				
Tend to interact/play with younger children?				
Enjoy time alone?				
Tolerate change in routine?				
Tolerate running errands?				
Enjoy eating in restaurants?				
Attending birthday parties?				
Attending family gatherings?				

Please provide any additional information that you would like to share about your child:

Child Name: _____

Person completing this intake form: _____

Best contact method? Email: Phone:

_____