Avon Occupational Therapy, Inc.

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Referral Intake Information Form

Child's Full Name: _____ DOB:_____
Parent(s) Name: _____
Home Address: _____
_____
Town: _____ State: _____ Zip Code: _____
Home Telephone #: _____ Cell Phone #: _____
Email Address:
_____

Child resides with: _____
_____

Reason for Referral / Parental Concerns:
_____
_____
_____
_____

Background Medical Information:

Name, Address, and Phone # of Pediatrician:
_____
_____
_____

Are there any food allergies, seizure history, medications, and / or medical conditions which might affect your child's ability to participate in evaluation or therapy activities? If yes, please describe and provide emergency

information (e.g. EpiPen, inhalers, latex allergies, seizure precautions, anxiety, etc.):

_____
_____
_____

Does your child have any medical restrictions currently in place? Please describe:_____
_____
_____

Child's Diagnosis or Presenting Medical / Developmental Concerns:

_____
_____
_____
_____
_____
_____

Please describe any significant medical history of family members (Mother, Father, Grandparents, Aunts / Uncles, and Siblings):

_____
_____
_____
_____
_____
_____

Please list any medications or supplements that your child is currently on:

_____
_____
_____

Does your child have any known or suspected allergies? Please list:

_____
_____
_____

Please describe your child's pre-natal, neonatal and birth history (if known):
_____
_____
_____

Complications during pregnancy and / or delivery? Yes / No. If yes, please describe: _____
_____
_____
_____

Please indicate whether your child was full term or pre-mature, type of delivery, and child's birth weight (if known):
_____
_____

Where was your child born? _____

Did your child require any specialized care at birth or soon after birth? Yes / No. If yes, please describe:_____
_____
_____
_____

Has your child had any surgical procedures or required any hospitalizations? Yes / No. If yes, please describe: _____
_____
_____
_____

Please list any Developmental or Medical Specialists, including Neurologist, Neuro Developmental Pediatrician, Developmental Optometrist / Ophthalmologist, etc. who are currently involved in your child's care?:
_____
_____
_____
_____
_____

_____

_____

Does your child require glasses, hearing aids, special shoe inserts, etc.?

_____

_____

Has your child ever received or does your child currently receive O.T., P.T., or Speech / Language Therapy? Please describe:_____

_____

_____

_____

_____

Developmental History:

How have developmental milestones been achieved to date?

_____

_____

If possible please list specific ages for the following milestones if they occurred and comment on anything unusual, such as method used for crawling:

- Roll over both ways? _____
- Sit alone? _____
- Crawl on hands and knees? _____
- Walk without assistance? _____

  _____
- Speak his / her first word? What was it? _____

  _____
- Drink from a cup independently? Type of cup currently being used?

  _____
- Use a spoon or fork? _____
- Feed himself / herself independently? _____

  _____
- Dress himself / herself independently? _____

  _____

_____

- Button independently? _____
- Toilet trained (day? night?) _____
- Tie shoe laces independently? _____
- Gallop? _____
- Skip with alternating feet? _____
- Pump a swing? _____
- Ride tricycle or bicycle? _____
- Exhibit a consistent hand preference? _____

Have there been or are there any current concerns with your child's sleep patterns or ability to self-soothe / self-regulate?

_____
_____
_____

Have there been or are there any current concerns with your child's feeding?

_____
_____
_____

Please describe how your child communicates: _____
_____
_____

Have there been or are there any current concerns with your child's sensory processing? (e.g. such as over responsiveness, under responsiveness, or seeking of touch, movement, sounds, smells, tastes, etc; having challenges with posture or doing unfamiliar activities; having challenges with transitions; exhibiting poor body awareness in space; and / or appearing "clumsy.") Please describe. _____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____

What are your child's "loves" or interests? / What does your child enjoy doing at home or in the community? _____
_____
_____
_____

Does your child participate in any organized activities in the community? (e.g. recreational activities, sports, lessons, etc.) Please describe.
_____
_____
_____

Do you have any concerns with your child's social emotional development? (e.g. does your child show interest in the world, engage / relate to others, demonstrate interest in peers, play in a variety of ways, represent ideas or feelings, think symbolically, participate in play dates or other social activities, etc.) Please describe. _____
_____
_____
_____
_____
_____
_____
_____
_____

Early Intervention / School History:

Does your child or did your child receive Early Intervention Services? Yes / No. If yes, please describe: _____

_____
_____
_____

What grade is your child currently in? _____

Does your child have a 504 Plan or an Individualized Educational Program (IEP)? Yes / No. If yes, please describe:

_____
_____
_____

Does your child participate in a general education, inclusion, or self-contained classroom? _____

Please list all of the schools / programs that your child has attended to date starting with preschool:

_____
_____
_____
_____
_____
_____

Does your child have any social, emotional, or academic difficulties at school? Yes / No. If yes, please describe:

_____
_____
_____

Please feel free to add any additional information or concerns below:

_____
_____
_____
_____
_____
_____

Signature of Parent / Legal Guardian: _____

Date: _____

Thank you for completing this form and assisting me in getting to know your child.