OT/PT Pediatric Intake Form

Child's name: _______________________________ Date: ____________

DOB: _______________________________________ Age: _____________

Parent/legal guardian names: ____________________________________

Home phone: _________________ Cell phone: ____________________

Child lives with (check one):

__ Birth parents	__ Foster parents	__ One parent
__ Adoptive parents	__ Parent and step-parent	__ Other: _____________

Concerns/goals: ____

____

____

Medical History (please list any prenatal/birth complications and history):

____

____

Birth weight: ______________________ Current weight: ________________________

Medications: ____

____

Allergies: ____

____

Up to date on immunizations? ____

School/day care? ____

Who cares for the child during the day? _________________________________

Positioning or mobility equipment? ____________________________________

Daily Routine: ____

____

Other Children in the Family:

Name	Age	Sex	Grade

Please tell the approximate age your child achieved the following:

_____________ sat alone

_____________ babbled

_____________ put two words together

_____________ walked

____________ grasped crayon/pencil

____________ said first words

____________ short sentences

____________ toilet trained