Mass General Brigham
Spaulding Rehabilitation

Date Completed: _____/_____/_____
Patient Name: _____
Date of Birth: _____/_____/_____

Occupational Therapy Intake

Developmental History

Did your child reach their developmental motor milestones (e.g., rolling, sitting, crawling, walking, etc.) when you expected? □ Yes □ No

Does your child struggle with or avoid coloring, scissor tasks, building with blocks/LEGOs, or manipulating small toys? □ Yes □ No

Does your child gravitate towards 'passive' activities (e.g., watching TV) or consistent play on either a tablet or smartphone? □ Yes □ No

Does your child struggle with everyday tasks (e.g., tooth brushing, bathing, dressing, eating, etc.) that you find other children their own age can manage? □ Yes □ No

What are your child's favorite toys/activities? _____

Sensory History

Do you have any concerns with your child's sensory processing skills? (if yes please, indicate below) □ Yes □ No

Oral	□ Seeks □ Avoids	Auditory	□ Seeks □ Avoids	Gustatory (taste)	□ Seeks □ Avoids
Tactile	□ Seeks □ Avoids	Visual	□ Seeks □ Avoids	Movement	□ Seeks □ Avoids

Do you consider your child overly active (e.g., struggles to sit and play, constantly on the move, considered to be a risk taker/climber, etc.)? □ Yes □ No

Does your child appear to have poor body awareness (e.g., bumps into things, trips, uses excessive force)? □ Yes □ No

Does your child struggle to function in busy or noisy environments? □ Yes □ No

Comments:_____

_____

Communication / Behavior

Is your child verbal? □ Yes □ No

Is your child able to communicate their needs? □ Yes □ No

Does your child have frequent temper tantrums? □ Yes □ No

Does your child present with aggressive behaviors? □ Yes □ No

Are you concerned with your child's safety awareness? □ Yes □ No

*Comments:*_____

_____

Self-Care / Activities of Daily Living

Do you have any concerns with your child's activities of daily living? (if yes please, indicate below) □ Yes □ No

	I have no concerns	I am concerned		I have no concerns	I am concerned
Dressing			Sleep		
Bathing			Feeding		
Grooming			Toileting		

Comments:_____

_____

What are your goals for therapy?_____

_____

Parent/Guardian Signature _____ Date:_____

Relationship to patient: _____