BACKGROUND INFORMATION AND OCCUPATIONAL INTAKE FORM

FAMILY INFORMATION

Child's name ______________________

Birth Date ____________ Age ________ Home/Cell Phone Number ________ / ____________

Parent's name ______________________

Address ______________________

Email ______________________

REFERRING INFORMATION

Who referred this child for an evaluation? ______________________

Reason for referral? ______________________

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

____

____

____

What are your child's strengths? ______________________

____

____

____

SCHOOL HISTORY

School Name and Teacher: ______________________

Grade: ______________________ Hand preference: Right ☐ Left ☐ Both ☐

Does your child receive special instruction or have an established IEP? ______________________

School based therapy? OT ☐ PT ☐ Speech and Language ☐

MEDICAL HISTORY

Any difficulties during pregnancy or delivery? No ☐ Yes ☐ If Yes please specify: ____________

____

____

____

____

Length of pregnancy: ______________ Birth was: ☐ Vaginal ☐ Caesarian ☐ Breech

Chronic ear infections? ☐ no ☐ yes ☐ tubes placed ☐ ________ sets of tubes

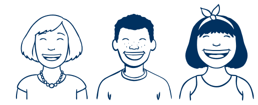
Current prescribed medications: ______________________

____

____

____

OCCUPATIONAL THERAPY



Known food allergies: ______________________________

____

____

Special Diet (GFCF, Ketogenic, pureed food only, tube feeding, etc.): ______________________________

____

____

Medical precautions: ______________________________

____

____

Diagnosis given by other health care professionals? ______________________________

____

____

Hospitalizations, date and length of stay: ______________________________

____

____

Surgeries? ______________________________

____

Currently receiving services from other health care professionals:
☐ Psychologist ☐ PT ☐ Speech and Language ☐ Nutritionist ☐ Behavioral Specialist ☐ Other:

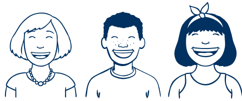
____

DEVELOPMENTAL HISTORY

Please check all the developmental milestones that your child *achieved*:

☐ rolling ☐ sitting alone ☐ creeping on all 4's ☐ pull to stand ☐ walking
☐ first word: _____ (age) ☐ combined words: _____ (age) ☐ finger feeding
☐ eating with a spoon ☐ cutting with a knife ☐ cutting with scissors ☐ jumping
☐ hopping on one foot ☐ riding a bike
☐ Developmental milestones were met: ☐ within typical age ranges ☐ delayed

OCCUPATIONAL THERAPY



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

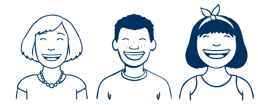
Self care:	Independent (completes without help)	I assist 50% or more	Dependent (total assistance needed)
Takes off pants:	☐	☐	☐
Puts on pants:	☐	☐	☐
Takes off shirt:	☐	☐	☐
Puts on shirt:	☐	☐	☐
Buttons:	☐	☐	☐
Zipper:	☐	☐	☐
Snaps:	☐	☐	☐
Puts on shoes:	☐	☐	☐
Takes off shoes:	☐	☐	☐
Ties shoes:	☐	☐	☐
Puts on socks:	☐	☐	☐
Takes off socks:	☐	☐	☐
Toileting:	☐	☐	☐
Bathing routine:	☐	☐	☐
Tooth brushing:	☐	☐	☐
Scooping with a spoon	☐	☐	☐
Spears with a fork	☐	☐	☐
Drinks from open cup	☐	☐	☐
Drinks from straw	☐	☐	☐

Describe your child at present:	YES	NO	SOMETIMES
Mostly quiet	☐	☐	☐
Overly active	☐	☐	☐
Tires easily	☐	☐	☐
Talks constantly	☐	☐	☐
Too impulsive	☐	☐	☐
Restless	☐	☐	☐

	SOMETIMES	YES	NO
Stubborn	☐	☐	☐
Resistant to change	☐	☐	☐
Fights frequently	☐	☐	☐
Usually happy	☐	☐	☐
Exhibits temper tantrums	☐	☐	☐

Describe: ____

OCCUPATIONAL THERAPY



	SOMETIMES	YES	NO
Clumsy	☐	☐	☐
Nervous ticks/habits	☐	☐	☐
Wets bed	☐	☐	☐
Frequency: ______________			
Poor attention	☐	☐	☐
Frustrated easily	☐	☐	☐
Unusual fears	☐	☐	☐
List: ______________			
Rocks self frequently	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Difficulty staying asleep	☐	☐	☐
Sluggish in the mornings	☐	☐	☐

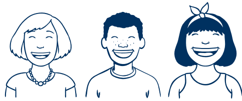
SOCIAL AND OCCUPATIONAL HISTORY

Does your child:

	OFTEN	SOMETIMES	RARELY
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?	☐	☐	☐

Does your child:

	OFTEN	SOMETIMES	RARELY
Tolerate running errands?	☐	☐	☐
Enjoy eating in restaurants?	☐	☐	☐
Attending birthday parties?	☐	☐	☐
Attending family gatherings?	☐	☐	☐



SENSORY PROCESSING

Any known difficulties with touch, taste, smell, sound, vision, movement, body awareness/ coordination, muscle tone, self regulation? ______

Examples include appearing not to hear oral directions, over-reactive to sounds, excessive movement/fidgeting, seeking out particular sensations. ______

Please provide any additional information that will help to better understand your child:

Thank You!

821 Al Wasl Rd
Al Safa 2
P.O. Box 334273
Dubai, UAE

T. +971 (0)4 380 2088
E. info@lighthousearabia.com

lighthousearabia.com