SALUS UNIVERSITY
Occupational Therapy Institute

Pediatric Intake Form

Client Information

Full Name: _____
Preferred Name: _____
Today's Date: _____
Date of Birth (dd/mm/yyyy): _____
Sex: _____

Check one or more options for the set(s) of pronouns you want people to use to refer to you:

- ❑ he, him, his
- ❑ she, her, hers
- ❑ they, them, theirs
- ❑ sie, hir, hirs
- ❑ Other: _____

Preferred Spoken/Written Language

- ❑ English
- ❑ Spanish
- ❑ American Sign Language
- ❑ Other:

Language interpretation services needed?

- ❑ No
- ❑ Yes, language: _____

This section is optional to complete:

Are you of Hispanic, Latino, or of Spanish origin? ❑ Yes ❑ No

How would you describe yourself? Check all that apply.

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ From multiple races
- ❑ Other: _____

Preferred Mailing Address:_____
Child's Grade: _____
Child's Daycare/School: _____
Current Therapy Services: _____

History of Therapy Services: _____
Current Diagnosis (if any): _____

Guardian Information

Parent/Guardian #1 Name:_____
Relationship to child:_____
Email:_____
Home Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Work Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Cell Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Address (if different from child):

Ok to disclose medical information ❑ Yes ❑ No

Ok to pick child up from therapy ❑ Yes ❑ No

Parent/Guardian #2 Name: _____
Relationship to child: _____
Email:_____
Home Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Work Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Cell Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Address (if different from child):

Ok to disclose medical information ❑ Yes ❑ No

Ok to pick child up from therapy ❑ Yes ❑ No

Parent/Guardian #3 Name: _____
Relationship to child:_____
Email:_____
Home Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Work Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Cell Phone: _____ day/evening OK to leave msg? ❑ Yes ❑ No
Address (if different from child):

Ok to disclose medical information ❑ Yes ❑ No

Ok to pick child up from therapy ❑ Yes ❑ No

Doctor Information
Pediatrician's Name:_____
Pediatrician's Phone Number:_____

Referral Information
Who referred you/client to our clinic? _____
Reason for referral: _____

What are your primary concerns?

_____
_____
_____

What do you hope to accomplish with therapy services?

_____
_____
_____

Does the client currently have any diagnosis? Please list:

_____
_____
_____

Has the client had any injuries, surgeries, illnesses or hospitalizations? Please list:

_____
_____
_____

Emergency Information Sheet

- ❑ **Check if the same as Guardian listed above**

Client Full Name:_____ Birth date:_____ Phone Number:_____
Contact Name: _____ Relation: _____
Work Phone Number: _____ Cell Phone Number: _____

If client becomes ill or involved in an accident and an emergency contact cannot be reached, I authorize the following hospital or above-named physician to give the emergency medical treatment required:
Hospital: _____ Address: _____
Parent/Guardian Full Name: _____
Parent/Guardian Signature: X_____
Date:_____

Medical History

How is the client's health general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

When was your last comprehensive medical evaluation? _____

Do you have any allergies to medications or other substances (pets, food, etc.)? ❑ Yes ❑ No

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis)

Please check any of the following diagnoses which apply to the client:

- ❑ Developmental Disorder
    - ❑ Autism Spectrum Disorder
    - ❑ Down Syndrome
    - ❑ Developmental Delays
    - ❑ Sensory Processing Disorder
    - ❑ ADHD
    - ❑ Intellectual and Learning Disabilities
        - ❑ Dyslexia
        - ❑ Dyscalculia
        - ❑ Dysgraphia
    - ❑ Other:_____
- ❑ Pulmonary and Cardiac Conditions
    - ❑ Cystic Fibrosis
    - ❑ Asthma
    - ❑ Tetralogy of Fallot
    - ❑ Other:_____
- ❑ Musculoskeletal
    - ❑ Muscular Dystrophy
    - ❑ Juvenile Rheumatoid Arthritis
    - ❑ Scoliosis
    - ❑ Congenital Limb Differences
    - ❑ Other:_____
- ❑ Psychosocial
    - ❑ Anxiety
    - ❑ Depression
    - ❑ Obsessive Compulsive Disorder (OCD)
    - ❑ PICA
    - ❑ Eating Disorder
    - ❑ Emotionally or behaviorally disturbance
    - ❑ Other:_____

- ❑ Neurological Disease/Disorder
    - ❑ Head Injury/Concussion
    - ❑ Epilepsy or other seizure disorder
    - ❑ Cerebral Palsy
    - ❑ Spina Bifida
    - ❑ Spinal Cord Injury
    - ❑ Other:_____

- ❑ Diabetes
    - ❑ Type 1
    - ❑ Type 2
- ❑ Obesity
- ❑ Cancer
    - ❑ Type/location:_____
- ❑ Visual Impairment
- ❑ Auditory impairment
- ❑ Pain
- ❑ Sleep problems
- ❑ Other: _____

Does the client currently take any medications/supplements/vitamins? Yes No

Medications:

_____
_____
_____

Supplements:

_____
_____
_____

Is there anything else you would like your occupational therapist to know before your evaluation or screening (ex. prior developmental difficulties, medical complications, personal preferences)?

_____
_____
_____

Optional:
Do you think anyone else in your household/residence would benefit from services?

- No
- Yes
    - If so please list, _____

Thank you for providing this information
Additional comments/personal or family history:

_____
_____
_____