LKS & ASSOCIATES
Speech and Occupational Therapy

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lksandassociates.com / www.lksanddasociates.com

Occupational Therapy Initial Intake Form / Parent Questionnaire

Patient First Name: ______________________________ **Last Name:** _______________________________

Child's birth date: _______________________________ **Today's date**: ______________________________

Relationship to child/ Person(s) completing this form: ____

How was your child referred to our clinic? ____

Child's School/ Grade: ____

Pediatrician: ____

Other medical specialists:

____

____

____

____

Has your child received a formal medical diagnosis? If yes, please explain.

____

____

____

____

Reason(s) you are seeking out occupational therapy services/ areas of concern?

____

____

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Please list specific goals you would like your child to achieve during therapy sessions:

____

____

____

____

MEDICAL/ DEVELOPMENTAL HISTORY:

Allergies:

____

____

____

____

Medical precautions:

____

____

____

____

Significant medical history (check and explain if appropriate):

☐ NICU stay
☐ ER Visits
☐ Surgery
☐ Seizures
☐ High Fevers
☐ Heart Ailments
☐ Respiratory Difficulties
☐ History of Ear Infections
☐ Reflux
☐ GI Issues
☐ Tubes in Ears
☐ Feeding Difficulties

Please explain:

Pregnancy history (stress, medical needs, etc.)

Type of delivery: ☐ vaginal birth ☐ caesarian

Significant birth history (check all that apply):
☐ Premature – how many weeks early: ______
☐ Drugs used during labor/ pregnancy: ______
☐ Forceps/vacuum delivery
☐ Abnormal APGAR scores: ______
☐ Abnormal/ prolonged time/length of labor: _____
☐ Other significant problems during/after birth (i.e., stuck in pelvis, oxygen required, etc.) ___

Describe your child's infancy:

____

____

____

____

Developmental Milestones (please specify age when reached):

Sits alone: ______ Crawled: ______ Cruised furniture: ______ Walked: ______ Babbled: ______ Finger Fed ______

Finger Fed: ______ Ate from Spoon: ______ Feeds with utensils: ______ Uses Single Words: ______

Combines Words: _____ Drink from an open cup: ______ Uses toilet: _____ Manages clothing for toileting: ______

Transitioned from bottle: _____ Transitioned from pacifier: ______

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SOCIAL HISTORY :

Current Living Situation (i.e. siblings and ages, etc.)

____

____

____

____

Does your child currently receive any other therapy services?

____

____

____

____

Has your child received therapy in the past? (If yes, please give dates/ frequency)

____

____

____

____

Does your child attend school or daycare? (Please give name, grade, and frequency of attendance)

____

____

____

____

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Does your child currently have an IEP (Individualized education Plan)? If yes, please list services and time/ frequency.

____

____

____

____

Has your child's teacher reported any concerns?

____

____

____

____

Does your child participate in extracurricular activities?

____

____

____

____

Does your child experience difficulty making or keeping friendships?

____

____

____

____

Does your child experience difficulty with behaviors and/or demonstrate limited coping and social emotional skills (e.g. tantrums often, etc.)

____

____

____

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Do you wish to share any other stresses your family is dealing with?

SELF-HELP/ ADAPTIVE SKILLS

Dressing Skills		
Dressing Skill	**Removes Independently**	**Puts on Independently**
Pants	☐ Yes ☐ No ☐ Not Consistent	☐ Yes ☐ No ☐ Not Consistent
Shirt	☐ Yes ☐ No ☐ Not Consistent	☐ Yes ☐ No ☐ Not Consistent
Socks	☐ Yes ☐ No ☐ Not Consistent	☐ Yes ☐ No ☐ Not Consistent
Shoes	☐ Yes ☐ No ☐ Not Consistent	☐ Yes ☐ No ☐ Not Consistent
Additional Comments:		

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Fasteners		
Fastener/ Skill	**Unfastens Independently**	**Fastens Independently**
Zippers	☐ Yes ☐ No ☐ Not Consistent	☐ Yes ☐ No ☐ Not Consistent
Buttons	☐ Yes ☐ No ☐ Not Consistent	☐ Yes ☐ No ☐ Not Consistent
Snaps	☐ Yes ☐ No ☐ Not Consistent	☐ Yes ☐ No ☐ Not Consistent
Ties Shoe laces	☐ Yes ☐ No ☐ Not Consistent	☐ Yes ☐ No ☐ Not Consistent
Additional Comments:		

Grooming/ Hygiene		
Adaptive Skill	**Completes Independently**	**Comments:**
Washes Hands	☐ Yes ☐ No ☐ Needs help for thoroughness ☐ Does not tolerate ☐ Unable	
Brushes teeth	☐ Yes ☐ No ☐ Needs help for thoroughness ☐ Does not tolerate ☐ Unable	

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Combs/ brushes hair	☐ Yes ☐ No ☐ Needs help for thoroughness ☐ Does not tolerate ☐ Unable	
Bathing	☐ Yes ☐ No ☐ Needs help for thoroughness ☐ Does not tolerate ☐ Unable	
Toileting	☐ Yes ☐ Not toilet trained ☐ Daytime toilet trained only ☐ Requires assistance to manage clothing	
Toileting Hygiene (wiping)	☐ Yes ☐ No ☐ Needs assistance ☐ Unable	
Sleep	☐ Sleeps through the night alone ☐ Co-sleeps through the night ☐ Does not sleep through the night ☐ Takes daily nap ☐ Difficulty falling asleep	
Hair cuts	☐ Tolerates ☐ Dos not tolerate ☐ Emerging	
Dentist Visits	☐ Tolerates ☐ Dos not tolerate ☐ Emerging	

Feeding

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Drinks from an open cup	**Drinks from a straw**
☐ Open cup ☐ Sippy cup ☐ Water bottle ☐ No, still uses bottle	☐ Yes ☐ No ☐ Attempts but has difficulty
Uses a spoon ☐ Yes ☐ No ☐ Attempts but has difficulty/ is messy	**Uses a fork** ☐ Yes ☐ No ☐ Attempts but has difficulty/ is messy
Uses a knife (e.g. to spread or cut) ☐ Yes ☐ No ☐ Attempts but has difficulty/ is messy	**Food Repertoire** ☐ Adequate ☐ Somewhat picky ☐ Extremely picky ☐ Requires modified diet

Is there anything else you would like to share with us before completing this form?

Thank you for your time and attention! We look forward to working with you and your child.