Mass General Brigham
Spaulding Rehabilitation

Date Completed:_____

Occupational Therapy Intake

Patient Information

Patient Name: _____ Date of Birth: _____

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? ◯ Yes ◯ No (If yes, please indicate below.)

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 concerns with your child's activities of daily living? ◯ Yes ◯ No (If yes, please select concerns below.)

☐ Dressing ☐ Bathing ☐ Grooming ☐ Sleep ☐ Feeding ☐ Toileting

Comments: _____

_____

What are your goals for therapy? _____

_____

_____

Parent/Guardian Signature:_____Date: _____

Relationship to patient: _____