



ASSIST Occupational Therapy Evaluation-- Initial Intake Info.

Child name: _____ D.O.B: _____ Age: _____
Preferred name or nick name? _____
Primary diagnosis: _____
Secondary diagnoses: _____
Educational placement: _____
Teacher/room # _____
Parents/caregivers: _____
Address: _____ Phone: _____
E-mail: _____

REFERRAL INFORMATION

Who referred your child to ASSIST occupational therapy? _____

Circle all previous/discontinued therapies provided:

Early intervention, (0-3 programs): occupational therapy, physical therapy, speech therapy.

Other: _____

School, (DOE): occupational therapy, physical therapy, speech therapy, counseling,
psychology services, SPED: _____

Other: _____

Private out of pocket: occupational therapy, physical therapy, speech therapy, counseling,
psychology service.

Other: _____

Circle all current therapies/support provided:

School, (DOE): occupational therapy, physical therapy, speech therapy, counseling,
psychology services, SPED: _____, tutoring

Other: _____

Private out of pocket: occupational therapy, physical therapy, speech therapy, counseling,
psychology services, tutoring, other: _____

Indicate any extracurricular activities your child participates in: team sports,
gymnastics, martial arts, art classes, therapeutic horsemanship, ACCESS surf, etc _____

What are you hoping this assessment will provide for you and your child?

SOCIAL HISTORY

Family concerns: _____



Goals for your child: _____

Child's favorite activities: _____

Child's favorite things and/or motivators: _____

RECENT MEDICAL HISTORY

Surgeries/Hospitalizations: _____

Current medications: _____

List any adaptive or medical equipment used, (i.e. manual/electric wheel chair, tub transfer bench, gait trainer, eye glasses, AFO's, etc) _____

List any allergies or special precautions when working with your child: _____

SENSORY PROCESSING (vision, hearing, touch, taste, smell, position/movement)

Circle or indicate all that apply to your child:

Vision: Light/dark sensitivity? Color preferences and/or avoidance?

Hearing: Auditory sensitivities--over-reacts to loud noises as if painful or irritating? Only appears to hear parts of words or instructions?

Touch: Tactile sensitivity--over-reacts to light touch as if irritating or painful?

Seeks deep pressure input? (firm touch, weights on body, pushing, pulling)

Taste/Smell: Food or smell aversions or cravings?

Position/Movement: Unreasonable fear of falling or overly anxious when feet leave the ground or when head is inverted? Avoids spinning or movement activities? Is easily motion sick?

Seeks spinning and movement activities--does not appear to become easily dizzy?

List any other behavioral anomalies or unusual responses to sensory stimulation:

SELF-CARE

Feeding

List any medical dietary restrictions? _____

Does your child have a limited diet due to food preferences/likes/dislikes? _____

Please explain limitations: _____

Does your child need extra assistance to get food to mouth or to use utensils? _____

Please explain assistance needed: _____

Dressing

Is your child an independent dresser? _____

Does your child have strong clothing preferences/likes/dislikes? _____

List clothing specifications: _____

Does your child leave clothes twisted on body or not seem to notice when clothes are backwards, inside out, etc? _____



Does your child need assistance with small fasteners, (buttons, zips, laces, bows, snaps)?

Please explain assistance needed: _____

Grooming/hygiene

Please circle all areas your child is independent with: face/hand washing, teeth brushing, hair brushing/washing, management, bathing, toileting, wiping.

Does child wear diapers for day/night? _____

Is child able to indicate toileting needs? _____

If extra assistance is needed for toileting, grooming and/or hygiene, please describe assistance needed: _____