OCCUPATIONAL / PHYSICAL / SPEECH INTAKE

PATIENT INFORMATION

Patient Name: _____ D.O.B. _____ ☐ M ☐ F

Last First M.I

Thank you for taking the time to fill out this form as completely and honestly as possible. Your input plays a very important role in the evaluation process. **Questionnaires not fully completed may delay scheduling your child for an evaluation and/or on-going treatment.** All the information on this form is confidential and will not be released without your permission.

OCCUPATIONAL (OT) / PHYSICAL THERAPY (PT) / SPEECH THERAPY (SLP)

What has led you to have concerns that your child may need Occupational / Physical Therapy or Speech Therapy?

Please answer the following question as detailed as possible (do not answer 'referred by primary physician').

SLP: LANGUAGE

☐ NO SPEECH CONCERNS
PLEASE SKIP SLP SECTIONS

How many words does your child speak? (please give an example)

Does your child combine words? (please give an example) ☐ Yes ☐ No

How does your child communicate (gestures, single words, short phrases, etc.)? (please give an example)

Does your child maintain eye contact while communicating? ☐ Yes ☐ No

Does your child understand simple questions or directions? ☐ Yes ☐ No

Do they follow 1 & 2 step directions? ☐ Yes ☐ No

Example:

SLP: FLUENCY

Does your child stutter or stammer and get stuck when speaking? (please give an example) ☐ Yes ☐ No

SLP: SOUND AND CLARITY

Do you have concerns with particular sounds or letters? (please explain)	☐ Yes	☐ No
Does your child sound like others their own age? (please explain)	☐ Yes	☐ No
Do you or others have trouble understanding your child? (please explain)	☐ Yes	☐ No
Does your child appear to be aware of his/her communication difficulties? (please explain)	☐ Yes	☐ No
Does your child respond to speech and/or different sounds in the environment? (please explain)	☐ Yes	☐ No

BODY AWARENESS / COORDINATION

Does your child appear clumsy when walking? (please explain)	☐ Yes	☐ No
Does your child have difficulty imitating a new motor skill? (please explain)	☐ Yes	☐ No
Does your child appear off balance/trips/runs into objects or people? (please explain)	☐ Yes	☐ No
Does your child tend to lean on furniture, people, or objects? (please explain)	☐ Yes	☐ No

FINE MOTOR DEVELOPMENT

Can your child:

Drink from a cup?	☐ Yes	☐ No
Dress / undress self (except for difficult fastening or tying)?	☐ Yes	☐ No
Use a toilet?	☐ Yes	☐ No
Write his/her own name?	☐ Yes	☐ No

MUSCLE STRENGTH/ENDURANCE

Does your child have difficulty keeping up with peers on the playground? (please explain)	☐ Yes	☐ No
Does your child get tired easily? (please explain)	☐ Yes	☐ No
Does your child have difficulty completing a motor skill/task more than 1 or 2x's in a row? (please explain)	☐ Yes	☐ No

MUSCLE TONE

Does your child appear to have low muscle tone/feels or looks floppy?	☐ Yes	☐ No
Or have high muscle tone/looks or feels stiff or rigid? (please explain)	☐ Yes	☐ No
Does your child have difficulty maintaining good sitting posture in a chair or on the floor? (please explain)	☐ Yes	☐ No
Does your child like to sit in a "W" position (knees together, feet pointing outward)? (please explain)	☐ Yes	☐ No

If your child is **3 years old or younger**:

Can your child walk without help?	☐ Yes	☐ No
Can your child run without help?	☐ Yes	☐ No
Can your child jump without help?	☐ Yes	☐ No
Can your child walk up/down steps holding onto a rail or your hand?	☐ Yes	☐ No

If your child is **4 years old or older**:

Can your child stand on one foot for three (3) seconds without help?	☐ Yes	☐ No
Can your child hop on one (1) foot by him/herself?	☐ Yes	☐ No
Can your child gallop?	☐ Yes	☐ No
Can your child climb a ladder?	☐ Yes	☐ No
Can your child throw and catch a playground size ball to a partner accurately?	☐ Yes	☐ No

SENSORY

Are there any specific behavior issues that the therapist should be made aware?
(aggression to others/physical outbursts/meltdowns/separation anxiety?)

Can you describe your child's behavior on a given day?

Morning Routine? Getting Ready? (i.e.: transitions, leaving house, relations with others, school or playground?)

SENSORY (CONTINUED)

Do you have trouble washing your child's hair, cutting hair or fingernails? (please explain) ☐ Yes ☐ No

Does your child like a lot of movement? Running, swinging, jumping? (please explain) ☐ Yes ☐ No

Does your child prefer to sit and play board games and/or coloring? (please explain) ☐ Yes ☐ No

SENSORY PROCESSING

Do any of the following statements descript your child?

Expresses distress during grooming (for example, fights, cries during haircutting, washing face, fingernail cutting)	☐ Yes ☐ No
Fears heights	☐ Yes ☐ No
Seeks all kinds of movement and this interferes with daily routines (for example, can't sit still, fidgets)	☐ Yes ☐ No
Jumps from one activity to another so that it interferes with play	☐ Yes ☐ No
Is distracted or has trouble functioning if there is a lot of noise around	☐ Yes ☐ No
Poor endurance/tires easily	☐ Yes ☐ No
Responds negatively to unexpected or loud noises (for example, cries or hides at noise from vacuum cleaner, dog barking, hair dryer)	☐ Yes ☐ No
Watches everyone when they move around the room	☐ Yes ☐ No

Please note any observations regarding the child's coordination while doing the following:

Coloring: _____ At what age? _____

Crawling: ☐ Four point ☐ Commando Crawl ☐ Bunny Hop ☐ Bottom Scooting At what age? _____

Cutting with scissors: _____ At what age? _____

Dressing his/herself (except for fasteners): _____ At what age? _____

Feeding his/herself: _____ At what age? _____

Jumping: _____ At what age? _____

Riding a tricycle: _____ At what age? _____

Running: _____ At what age? _____

Sitting: _____ At what age? _____

Standing: _____ At what age? _____

Toilet training: _____ At what age? _____

Walking up/down stairs: _____ At what age? _____

Walking: _____ At what age? _____

FEEDING HISTORY AND DEVELOPMENT ☐ **NO FEEDING CONCERNS**
PLEASE SKIP FEEDING SECTIONS

What has led you to have concerns that your child may need feeding therapy?
Please answer the following question as detailed as possible (do not answer 'referred by primary physician').

FEEDING HISTORY AND DEVELOPMENT

Does your child have a history of GERD? (spit ups, excessive vomits?) ☐ Yes ☐ No
If any, when: _____
Frequency: _____
Has your child had any diagnostic testing related to eating? (please include name of test and date(s)) ☐ Yes ☐ No

Did your child require any alternative feeding methods? (if yes, please state for how long) ☐ Yes ☐ No

Has your child been on any type of special diet? ☐ Yes ☐ No
(if yes, describe type of diet, at what age, why and how did your child respond)

At what age did your child transition to:
Baby Cereal: _____ Baby Food: _____ Finger Food: _____ Transition fully to table food: _____

Describe your experience/difficulties with starting solid food(s):

Describe your experience/difficulties with introducing a cup:

CURRENT FEEDING STATUS

Is your child a vegetarian? ☐ Yes ☐ No

List any food and/or non-food (medication) that your child is allergic to:

Does your child:	☐ Prefer ☐ Dislike	Hard food? (chips/meat)	Explain:
	☐ Prefer ☐ Dislike	Soft foods? (fruit/veggies)	Explain:
	☐ Prefer ☐ Dislike	Slippery foods? (bananas/peaches)	Explain:

PLEASE SPECIFY LIKES/DISLIKES FOR TASTE, SMELL, TEXTURE, COLOR, ETC. IN REGARDS TO FOOD

LIKES LIST THE ITEMS THAT YOUR CHILD CURRENTLY **WILL** EAT AND DRINK	**LIKES** LIST ITEMS THAT YOUR CHILD CURRENTLY **WILL NOT** EAT AND DRINK	
	ITEM/FOOD	REACTION/BEHAVIOR

SELF-FEEDING

Does your child feed self? ☐ Yes ☐ No

Can your child use utensils? If Yes, please describe any special cup/bowl used; If no, who feeds child? ☐ Yes ☐ No

Can they move towards mouth? (please explain) ☐ Yes ☐ No

Does your child mind a messy face when they eat? (please explain) ☐ Yes ☐ No

Does your child gag or throw up when eating? (please explain) ☐ Yes ☐ No

Where does your child eat? What type of chair is used?

Who eats with your child?

How long does it take for your child to eat or be fed?

Are there any other activities going on at meals?

FEEDING DIARY

Please list/keep a diary of what your child eats in a typical week. You need to complete this form based on the guidelines listed below. It is important to complete this form to help us find a group that will be the best match for your child.

1. Please fill out all the boxes in the table. If your child did not eat anything for a meal, please write in detail regarding: what was offered, did your child take a bite of any food, etc.
2. Please write down the day and date that your completed this diary. It is useful to carry this record with your and note down the details immediately so that you don't miss any information.
3. Please include the list of food items your child ate for each meal. Also include specifics for that type of juice he/she drinks; any additions to food that he/she likes (e.g. dressing, sauces, gravies, butter, etc.) and the form of the food/drink (solid, pureed, thickened, etc.)

	Breakfast	Snack	Lunch	Snack	Dinner/Supper
Day 1 Day: _____ Date: _____					
Day 2 Day: _____ Date: _____					
Day 3 Day: _____ Date: _____					

PARENT PERSPECTIVE

Describe how you and your child feel after completing meals:

You: _____

Your Child: _____

List some goals you want your child to work on during therapy/feeding classes. How can we help your child best?

HANDWRITING CONCERNS ☐ **NO HANDWRITING CONCERNS** — **PLEASE SKIP HANDWRITING SECTIONS**

Does your child have a hand dominance? ☐ Yes ☐ No ☐ Undecided If so, which one? ☐ RIGHT ☐ LEFT

What are your concerns with your child's handwriting:

Handwriting problems reported or noticed? (please explain) ☐ Yes ☐ No

How would you describe your child's attention?

Does your child receive any other specialized tutoring or services? (please explain) ☐ Yes ☐ No

Any other concerns with regards to your child's handwriting? (please explain) ☐ Yes ☐ No

HANDWRITING RATING SCALE FOR STUDENTS

1. Do you enjoy handwriting?
   - ❒ All the time
   - ❒ Most of the time
   - ❒ Sometimes
   - ❒ Hardly ever
   - ❒ Never

2. How hard is handwriting?
   - ❒ Very easy
   - ❒ Easy
   - ❒ Just OK
   - ❒ Hard
   - ❒ Very hard

3. What do you think about your writing?
   - ❒ It's fantastic
   - ❒ It's great
   - ❒ It's OK
   - ❒ It's not so good
   - ❒ It's terrible

4. What does your wiring look like compared to other classmates?
   - ❒ Heaps better
   - ❒ Better
   - ❒ The same
   - ❒ Not as good
   - ❒ Heaps worse

5. Do your eyes ever feel sore when you are writing?
   - ❒ Yes
   - ❒ Sometimes
   - ❒ No

6. Does your work or the lines on the page ever look blurry?
   - ❒ Yes
   - ❒ Sometimes
   - ❒ No

7. Do you have difficulty copying work?
   - From the blackboard? ❒ Yes ❒ No
   - On your desk? ❒ Yes ❒ No
   - If yes, what is the problem?
   - ❒ Too Slow
   - ❒ Miss words
   - ❒ Other: _____

8. Do you keep up with the class when writing?
   - ❒ Yes
   - ❒ Sometimes
   - ❒ No

9. Do you want to improve your writing?
   - ❒ Yes
   - ❒ No

10. What do you want to improve about your writing?

_____

_____

_____

HANDWRITING RATING SCALE FOR PARENTS	Exceptionally Good	Very Good	Good/ Average	Slightly Below Average	Extremely Poor
	1	2	3	4	5
What is your child's pencil grasp like: ☐ Low Grip ☐ High Grip ☐ Fist					
What is your child's handwriting like:					
Does your child tear the paper or break the lead when they write? ☐ Yes ☐ No					
What is your child's handwriting like when he/she has to write quickly?					
What is your child's handwriting like when he/she has to write for long periods?					
What is your child's sitting posture like?					
How would you rate your child's attitude to writing?					

	Never	Rarely	Sometimes	Frequently	Nearly Always
	1	2	3	4	5
Does your child need assistance to complete his/her written homework?					
Does your child complain of sore eyes during/after reading and/or writing?					
Does your child complain of blurred vision during/after reading and/or writing?					
Does your child complain of soreness during writing?					
Does your child complain of tiredness during writings?					

Are there any other comments you would like to make about your child's handwriting? (please explain) ☐ Yes ☐ No

OCCUPATIONAL / PHYSICAL / SPEECH INTAKE

Name of Student: _____ Chronological Age: _____

Teacher: _____ Year: _____

Date: _____

1. Please rate these components of the student's finished handwriting product:
(take into account the child's ability in relation to age/year expectations)

	Exceptionally Good	Very Good	Good/ Average	Slightly Below Average	Extremely Poor
	1	2	3	4	5
Overall quality of handwriting compared with peers					
Speed of writing					
Neatness of writing					
Understanding of the rules of letter formation					
Closure of letters					
Absence of reversals					
Joining of letters (if appropriate)					
Consistent size of letters (appropriate for child's age)					
Placement of letters and words on the line					
Spacing between letters and words					
Pencil grasp					
Sitting posture					

2. How much pencil/pen pressure does the student apply to the paper?
☐ A lot ☐ Average ☐ Too light

3. Please rate the student's ability to do the following:

	1	2	3	4	5
Copy work from near-point (e.g. textbook)					
Copy work from a far-point (e.g. board)					
Write from dictation					
Complete set work in a set time frame					
Generate own ideas to write a story					

4. Does the student ever complete of sore eyes during/after reading and/or writing?
☐ Often ☐ Sometimes ☐ Never

5. Does the student ever complain of blurred vision during/after reading and/or writing?
☐ Often ☐ Sometimes ☐ Never

6. Please rate the student's performance on manipulative tasks:

	1	2	3	4	5
Scissor manipulation					
Cutting accurately along lines					
Pasting					
Using a ruler					
Using an eraser					
Coloring					
Tracing					
Drawing					
Manipulating small objects (e.g. counters, blocks)					
Manipulating a computer mouse (i.e. click, target, drag)					
Using a keyboard					

Thank you for taking the time to complete this rating scale.