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Occupational Therapy New Client Intake Form

Child's Name: _____ Today's Date: _____
DOB: _____ Parent's Name: _____
Medical Dx: _____ Phone Number: _____

Birth History

Born at _____ weeks gestation. Birth weight: _____
Born by vaginal or cesarean delivery? _____
Did your child require NICU care? _____
Significant birth, medical, surgical history: _____

Medical Background

Current medical condition: _____

Current medications: _____
Any known allergies?: _____
Does your child wear glasses?: _____ Hearing aides?: _____
Has your child had a vision screening? If so, results: _____
Has your child had a hearing screening? If so, results: _____
Does your child have an history of ear infections? _____
Has your child had tubes placed in the ears?: _____

Therapy History

Therapies currently receiving: _____
Therapies received in the past: _____

Social Background

Currently attending school/grade: _____
Academic strengths/weaknesses: _____
Primary caregivers during the day: _____
Child lives with: _____

Child's Current Level of Function

Sensory Processing

Does your child seem over or under sensitive to sensory input?

Sounds: _____
Touch: _____
Movement: _____
Light: _____
Pain: _____
Temperature: _____
Clothing: _____

On a scale on 0-5 (0=not at all, 5=very much so), rate how well these behaviors describe your child:

- Likes going barefoot: _____ Tolerates hair brushed: _____
- _____
- Gives big, hard hugs: _____ Tolerates teeth brushed: _____
- _____
- Fidgets, squirms: _____ Covers ears during loud sounds: _____
- _____
- Seems distractible: _____ Avoids eye contact: _____
- _____
- Has frequent tantrums: _____ Seems coordinated: _____
- _____
- Speaks loudly: _____ Picky eater: _____
- _____
- Seems messy: _____ Seems organized: _____

Self-Care, Play Skills

Does your child make friends easily, play well with others? Describe: _____

Can your child swim? _____ Ride a bicycle? _____

Please check the box which best describes your child's self-care skills:

	Independently	With a little help (up to 25%)	With some help (Up to 50%)	With lots of help (Up to 75%)	Total help needed (up to 100%)
<u>TAKE OFF:</u>					
Socks					
Shoes					
Pants					
Shirt					
<u>PUT ON:</u>					
Socks					
Shoes					
Pants					
Shirt					
<u>FASTEN:</u>					
Velcro					
Buttons					
Zipper					
Snaps					
Shoe laces					
<u>MEALS:</u>					
Finger feed					
Use fork					
Use spoon					
Use knife					
Drink from cup					