OT Solutions
Pediatric Occupational & Speech Therapy

PARENT OT INTAKE REPORT

Today's Date: _____ Your Name: _____

Child's Full Name: _____ DOB: _____

Parent/Guardian: _____

Address: _____

Phone: _____ Alternate Phone: _____

Email: _____

Insurance Carrier: _____ Insurance Number: _____

Who referred you to OT Solutions Inc.? _____

Name of primary pediatrician: _____

Do you have a referral from your child's pediatrician? YES NO

Has your child been to see pediatrician in the last 12 months? YES NO

Other medical professionals your child is currently seen by:

_____

_____

Background Information:

Full-term pregnancy? YES NO If no, how many gestational weeks? _____

Please list any hospitalizations/surgeries and reasons and dates:

_____

_____

Any Allergies? YES NO List: _____

Please list any birth history or medical history:

_____

_____

1911 S. 17th Street Suite 100 Wilmington, NC 28401 910-313-2111/910-313-2119 fax

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Does your child have any medical diagnoses? Please list and when:

_____

_____

_____

Please tell us a little about your child's strengths and accomplishments:

Please circle any concerns that you have today:

fine motor skills	strength	movement	clumsiness
school/academics	vision	hearing	sleep patterns
gross motor skills	arousal level	tantrums	head banging
hand- flapping	Covering ears	sensitivities	feeding/eating
toileting/training	social skills	overly active	attention span
aggression	play skills	behaviors	coping skills

Other concerns you may have:

Has your child ever received OT in the past? YES NO
When/Where: _____

Does your child attend school? YES NO Where: _____

Does your child have a current IEP? YES NO

Thank you for providing us with this helpful information!!

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