PIN:

Mailing Address:
755 Martin Luther King Jr. Way, MSC 9022
Harrisonburg, VA 22801
Physical Address:
131 W. Grace St., Rm 1100
Harrisonburg, VA 22807

Fax: 540-568-2645
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JMU OTCES Initial Intake Form

Date Completed: _____ Completed by:_____ Relationship to child: _____

Child's Name _____ ☐ Female ☐ Male
First Middle Last Nickname

Child's Date of Birth_____ Is the child adopted? ☐ **Yes** ☐ **No** Is the child in foster care? ☐ **Yes** ☐ **No**

Child Resides With: ☐ Mother(s) ☐ Father(s) ☐ Other (specify) _____

LEGAL GUARDIANS OR PARENTS WITH LEGAL RIGHTS

(provide custodial documents as necessary)

Legal Guardian/Parent Name:_____ Relationship to child: _____

Address: _____
Street/Apt. # City State Zip Code

Home Phone #: (_____) - _____ Cell Phone #: (_____) - _____ Email: _____

Occupation: _____ Work Phone #: (_____) - _____

Legal Guardian/Parent Name:_____ Relationship to child: _____

Address: _____
Street/Apt. # City State Zip Code

Home Phone #: (_____) - _____ Cell Phone #: (_____) - _____ Email: _____

Occupation: _____ Work Phone #: (_____) - _____

PARENTS WITH LIMITED or WITHOUT LEGAL RIGHTS

(provide custodial documents as necessary)

Name	Relationship

PERSONS LIVING IN THE CHILD'S PRIMARY HOME

Name	Relationship	Age

IMMEDIATE FAMILY LIVING ELSEWHERE (parents, siblings)

Name	Relationship	Age

SCHOOL INFORMATION

Name of Child's School: _____

Address: _____
Street City State Zip Code

Grade: _____ Teacher's Name: _____

Has the child been evaluated for special education services? □ **Yes** □ **No** If yes, when? _____

Does your child have a: □ 504 Plan □ IEP **If yes, please provide a copy of the IEP/504 Plan**

What services are included (check all that apply):

Speech therapy ___ Behavioral therapy___ Physical Therapy ___ Occupational Therapy ___ Other:_____

PRIMARY HEALTH CARE PROVIDER (PCP)INFORMATION

Provider Name: _____

Name of Provider Practice:_____

Address: _____
Street City State Zip Code

Phone # :_____ Fax #: _____

How long has your child been seeing this provider? _____

REFERRAL INFORMATION

What are **your** primary concerns, related to your child, that you would like addressed during the OT evaluation?

_____

_____

Were you referred for an OT evaluation by someone else? □ Yes □ No
If yes, who referred you?

Name:_____Relationship to child:_____

Primary Concerns:_____

_____

HEALTH INFORMATION

Pregnancy/Birth History

	Yes	No	N/A	Comments (if yes, please provide additional information)
Did mother experience any medical complications during pregnancy, labor, or delivery?				
Did mother take any medications during pregnancy or labor?				
Were APGAR scores normal at birth?				
Did the child experience any medical complications before, during or after birth?				
Did the child have an extended stay at the hospital following birth?				If yes, how long?
Did the child require tube feedings?				If yes, how long?
Was your child breast fed?				If yes, how long?
Did your child have difficulty with feeding?				

What was the child's gestational age and birth weight? Age: _____weeks Weight_____lbs_____oz.

Medical History

	Yes	No	N/A	Comments (if yes, please provide additional information)
Has your child received a specific diagnosis (i.e. Autism, hypotonia, learning disability, etc.)?				
Does your child have allergies?				
Does your child have seizures?				
Did your child experience any complications from vaccinations?				
Does your child have any significant medical issues (respiratory, heart, broken bones, stitches, other)?				
Does your child have a history of ear infections?				
Has your child been hospitalized or required surgery?				
Does your child have a history of GI issues (i.e. constipation, chronic diarrhea, reflux, other)?				
Has your child had a vision screening?				Date of screening & results:
Has your child had a hearing screening?				Date of screening & results:
Has your child had a physical exam within the last year?				Date of exam & results:
Does your child currently take medication?				List Current Medications (Attach list as needed):

Healthcare Providers

(Please include all providers since birth)

	Provider Name	Dates	Reason/Results
Medical Specialists *(i.e. Neurologist, Gastroenterologist, Ophthalmologist, etc.)*			
Mental Health Professional (Psychiatrist, Psychologist, counselor, etc.)			
Rehab or Developmental Therapist *(OT, SLP, PT, etc.)*			
Other Specialists (vision or hearing impaired, orientation & mobility, etc.)			
Other (Dept of Social Services, case management, etc.)			

Please attach a list if needed.

PSYCHOSOCIAL HISTORY

Please use the attached form "Pediatric ACEs and Related Life Events Screener (PEARLS)" and follow the checklist's instructions: Please complete to the best of your ability.	**# of "yes" responses**
PART 1:	**#**
PART 2:	**#**

https://www.acesaware.org/wp-content/uploads/2019/12/PEARLS-Tool-Child-Parent-Caregiver-Report-Identified-English.pdf

DEVELOPMENTAL INFORMATION

Auditory/Language History

My child:	**Yes**	**No**	**N/A or Comments**
Uses an alternative form of communication (ASL, PECs, device, etc.)?			Please indicate which method of communication:
Speaks a language (other than English) at home			Language spoken in the home:
Has difficulty speaking clearly/being understood			
Needs additional time to process things said to them			
Relies on visual cues to know how to respond			

Self-Care

My child:	**Independent (met on time)**	**Independent (delayed development)**	**Requires Assistance (a little, some, a lot)**	**Comments (include use of special equipment)**
Eats solid foods				
Drinks from an open cup				
Drinks from a straw				
Finger feeds self				
Feeds self using utensils				
Opens food containers (bags, storage containers)				
Dresses self (shirt, pants, socks, shoes, coat)				
Undresses self (shirt, pants, socks, shoes, coat)				
Manages clothing fasteners (zip, button, snap)				

Orients clothing correctly on body (e.g. Front/Back, L/R)				
Is toilet trained				
Completes basic hygiene routines (hand washing, teeth brushing)				
Has difficulty with sleep routines				
Refuses a lot of foods (picky eater, refuses to try new foods)				What foods are preferred? Avoided?
Chokes or gags when eating or drinking?				

Cognition/Executive Functioning

My child:	Yes	No	Comments
Has difficulty following directions, rules, or responding positively to adult-direction?			
Has difficulty paying attention or become easily distracted?			
Requires a lot of 1-1 support to be successful in getting things done?			
Has difficulty with planning, organizing, or managing their time?			

Social & Emotional

My child:	Yes	No	Comments
Engages in creative/pretend play (dress-up, acting out stories).			
Prefers to play games or with toys that are for younger children.			
Prefers to play with children who are younger or much older.			
Has difficulty playing by him/herself.			
Has difficulty playing with others (e.g. may prefer to play alone)			
Has difficulty taking turns or sharing.			
Avoids or becomes fearful or confused/anxious in social situations.			
Has difficulty expressing emotions or saying how he/she feels.			
Lacks confidence, give up easily, or seem to have poor self-esteem.			
Approaches tasks or people impulsively.			
Has extreme/abnormal mood changes (e.g. tantrums, etc.).			
Has difficulty with changes in routine or transitioning between activities without becoming upset.			
Tries to escape to a quiet place to calm down when overwhelmed.			

Sensory Processing

My child:	Yes	No	Comments
Avoids or overreacts to certain feelings/sensations? (e.g. getting dirty, grass, bright lights, being touched, noise)			
Seeks certain feelings/sensations? (e.g. hugs, jumping, crashing, tastes, noise)			
Has an unusually high or low pain threshold? **(circle one)**			
Gets nauseous or fearful when moving through space (car rides, swinging)?			
Seems unaware of how to move their body or frequently run into things?			

Seems unaware of certain sensations (sounds, touch, visual, taste, smells)?			
Has difficulty knowing when he/she needs to go to the bathroom or when hungry or full?			

Motor Skills

My child:	Independent (met on time)	Independent (delayed development)	Requires Assistance (a little, some, a lot)	Comments or N/A (include use of special equipment)
Rolls over both directions.				
Sits without support				
Crawls on hands and knees				
Walks without support				
Climbs/descends stairs alternating feet				
Rides a riding toy with pedals				
Rides a bike w/o training wheels				
Uses a pincer grasp to pick up small items				
Points using index finger				
Holds utensils with thumb and fingers				

Additional Information

My child:	Yes	No	Comments or N/A
Becomes tired quickly, seems weaker, or has less endurance than others.			
Avoids physical activity/sports; prefers sedentary activities.			
Has difficulty with hopping, jumping, skipping, or running compared to others.			
Has difficulty with ball skills (throwing, catching, hitting, kicking, dribbling).			
Appears clumsy and/or, stiff when moving.			
Avoids or has difficulty playing on playground equipment.			
Has difficulty learning new motor tasks.			
Has difficulty tracking a moving object with eyes/unusual eye movements.			
Has difficulty locating objects in a distracting background (i.e. cluttered, maps).			
Has difficulty completing age-appropriate puzzles.			
Has difficulty with or avoid constructional activities (blocks, legos, etc.).			
Has difficulty writing, drawing and/or cutting.			
Reverses letters and/or numbers.			

Demonstrates hand dominance.			Circle one: Left Right
Knows left and right.			

Additional Information

What are your child's strengths?_____

_____

_____

What are your child's likes?_____

_____

_____

What are your child's dislikes?_____

_____

Does your child participate in community programs or activities (i.e. soccer, music lessons, drama classes, etc.)?

_____

_____

What do you find to be most challenging with respect to supporting your child to engage in his/her daily routines?

_____

_____

What are some strategies that have been used (home, school, community) that have been helpful in supporting your child to be successful?

_____

_____

_____

_____

What would you like for your child to accomplish by participating in OT (What are your primary goals)?

_____

_____

_____

Is there any additional information you would like to share about your child?

_____

_____