every person develops
Occupational Therapy, Inc.

915 Middle River Dr. Suite 320 D
Fort Lauderdale, FL, 33301

PH 954-440-7598 / Fax 9547691876
Info@EPDTherapy.com

THERAPY INTAKE FORM

*Seeking therapy services for the first time can be overwhelming and confusing. Here at **EPD Occupational Therapy Inc.,** we are committed to make this experience as easy and comforting as possible. Please understand the importance of filling out this questionnaire. The information requested below is necessary for us to determine how much time to allow for the appointment requested.*

It is essential that we receive a completed form prior to the time of your scheduled appointment in order to best prepare testing and equipment required.

We have shortened our form to make this task as easy as possible for you and appreciate your compliance. After reviewing this initial intake form, we may ask that you provide additional information necessary to develop the best Plan of Care for you or your family member.

Take your time to complete past medical history, education setting, and background information so we can best meet your family member's needs. Bring necessary equipment to meet your child's immediate needs and dress him/her in comfortable clothing and closed toe shoes.

How did you hear about us?

_____

Are you requesting ☐ Free Screening/ Consultation ☐ Formal Evaluation ☐Re-Evaluation

What is your availability for the appointment/ evaluation requested and future therapy appointments?

_____

We will do our best to accommodate your needs!

PARENT / CARE GIVER INFORMATION

Name(s):_____

Parent Occupation:_____

Contact information/ Phone numbers:

_____

e-mail: _____

Primary language: _____ Other: _____

Address: _____ City: _____ State: _____

Zip code: _____

Emergency contact: _____

PLAN OF PAYMENT/ INSURANCE INFORMATION

Method of payment: ☐ Self Pay ☐ Insurance Plan

Primary Insured name: _____ DOB: _____/_____/_____

Name of Insurance: _____Member ID: _____co-pay:_____

CLIENT INFORMATION

Legal Name: _____Preferred nick name: _____

D.O.B: ____/_____/_____ Gender: ☐ M ☐ F Primary Dx._____

Secondary: _____

Current Status: *(Please include who the client lives with and including siblings, grade level of client, special school programs)*

_____

_____

_____

Previous therapy history: *(Please bring any copies of previous evaluations and or current goals)*

_____

_____

What services do you seek from us? ☐ Skilled OT ☐Speech and Language ☐ Physical Therapy ☐ Specialty treatments circle (Interactive Metronomes, Therapeutic Listening, Astronaut Training, Handwriting without tears, Pragmatic Partners/ Social Skills groups)

☐ Other: _____

Why you seek them? What is your chief complaint? (Describe difficulties your child is experiencing)

_____

Hand dominance: ☐ R ☐ L Obtained efficient grasping/ hand function? ☐ Yes ☐ No

Comment on achievement and difficulties

Fine motor skills_____

Gross Motor Skills: _____

Social Function: _____

Sensory Concerns: _____

Activity Level: ☐ High ☐ Average ☐ Low

Comments: _____

Attention Span: ☐ Excellent ☐ Good ☐ Fair ☐Poor

Comment: _____

_____

_____

_____

What are your expectations? _____

Is the client being seen in any pain? ☐ Yes ☐ No If yes, please explain: _____

Client interests: (*Please comment on child interests in order for us to motivate him/ her and engage therapeutic play activities)*

_____

_____

_____

_____

PAST MEDICAL HISTORY

Please describe any pertinent medical conditions, current medications, adaptive devices:

_____

_____

_____

_____

PRECAUTIONS

Please state clearly any precautions such as allergies, diet restrictions, and if your child has history of seizures:

_____

_____

BACKGROUND INFORMATION

Pregnancy term: Full term ☐ Yes ☐ No _____ Complications: ☐ Yes ☐ No

_____

Delivered: ☐ Vaginally ☐ C- section Weight: _____ Apgar score: _____

DEVELOPMENTAL HISTORY

Please state date (weeks/ months) obtained:

Sat alone _____ rolled over_____ crawled _____ cruising_____ walked_____

First words_____ Does your child functionally communicate ☐ Yes ☐ No Toilet trained ☐ Yes ☐ No

Please comment and report milestones and delays/ complications if any? _____

_____

_____

SELF CARE AND SELF HELP SKILLS

Please comment how much client needs help and what they can perform independently.

Dressing: _____

Bathing/ Hygiene: _____

Grooming: _____

Toileting: _____

Eating: _____

Mobility: _____

Postural Limitations: _____

School Function: _____

Thank You!

EPD Occupational Therapy Inc.

We are looking forward to HELPING YOUR CHILD!