Client Intake Form

Background Information

Name of Child	
Date of Birth	
Date of Evaluation/First Session	
What do you want your child to get out of OT? Main goals/concerns?	
Name of Person Completing This Form	
Best Contact Phone Number	
Home Address	
Name of Pediatrician	
How did you hear about us?	

Past Medical History

Any Pregnancy Complications	
Any Birth Complications	
Gestational Age at Birth	
Birth Weight	
Previous/Current Therapies	
Any Current Medications	
Allergies	
Vision Problems	
Hearing Problems	
Age at independent sitting	
Age at Independent crawling	
Age at independent walking	
Any Medical Diagnoses	
Dates of Given Medical Diagnoses	
Other Relevant Medical History	

Home Life Information

Who Lives at Home?	
Other Family Members Your Child Sees Frequently	
Any Pets	
Home Layout (one story/two story, stairs)	
Does Your Child Participate in Any Chores?	
Child's Preferred Toys	

Educational Information

Grade	
School	
Class Make-Up (# children, # teachers # aides, etc.)	
IEP/504?	
In Person, Virtual, or Hybrid	

How Does Your Child Do With…

ADL Skills (self-feeding, dressing, bathing, grooming, toileting)	
Fine Motor Skills (grasp, handwriting, manipulation)	
Gross Motor Skills (catching, throwing, jumping, climbing)	
Visual Perceptual/ Motor Skills (tracking, puzzles, connect the dots, patterns, letter recognition)	
Social Skills (eye contact, turn taking, transition from parent)	
Emotional Regulation (coping skills, frustration tolerance)	
Neuromuscular Skills (overall strength, weight bearing stamina)	

CONSENT TO TREAT STATEMENT:

I, _____, give permission to Play By Day, LLC to treat my child _____ for occupational therapy services. I give them permission to bill my insurance for services and agree to pay any applied co-pay or co-insurance as indicated by my insurance provider.

Signature: _____
Relation to child: _____
Date: _____