2261 Town Center Ave #109 Viera, FL 32940 P: 321-255-7779 F: 321-255-7774

7 Senses Kids
OT STUDIO & ECO SHOP

Client Intake Form 2021

Date: _____

Client Name: _____ DOB:_____ School: _____
Grade: _____Diagnosis: _____
Child Enjoys: _____
ALLERGIES: _____

Mother/Guardian: _____ Profession: _____
Employer: _____ Work Hours per Week: _____
Favorite Activity with Child: _____
_____Single _____Married _____Divorced

Father/Guardian: _____ Profession: _____
Employer: _____ Work Hours per Week: _____
Favorite Activity with Child: _____

Address: _____
Home Phone: _____ Work: _____ Cell: _____
Email: _____

Have you had Occupational / Speech Therapy before? _____ Yes _____ No
When: _____
Who may we thank for referring you to our office?: _____

Physician/Pediatrician: _____
Physician Address: _____
Physician Phone: _____ Fax: _____

Pediatric Health History/Development

1. Please describe any significant illnesses/difficulties/traumas during the pregnancy with this child:
   _____
   _____

2. Please check off all that apply to the birth of this child: Home birth _____ Hospital _____
   Epidural _____ Episiotomy _____ Vaginal _____ Forceps _____ C-section _____
   Vacuum _____ Manual Assistance _____ Medications _____

3. Length of Labor: _____
4. Was the baby breastfed? _____ If yes, for how long? _____
5. Has your child received vaccinations YES or NO Complete for their age: _____ Partial: _____
   No vaccinations: _____

6. Age child rolled: _____ Age child talked: _____ Age child crawled: _____
   Age child walked: _____

7. What time does the child go to bed?: _____ How long to they sleep?:_____
   Any concerns with sleeping and the bedtime routine:
   _____
8. What does the child eat?:_____
   Any eating concerns: _____
9. Child's Activity/exercise level: _____Hrs per week:_____
   Do they play any sports?:_____
   Any concerns with movement/activity level?: _____
10. Mental Health concerns?: _____

11. Please describe any falls, stitches, fractures, car accidents, sports injuries or other traumas that your child experienced since birth (include ages and dates):
    _____
    _____
12. Please tell us about any health issues/chronic illnesses that the child has had since birth (include ages/dates): _____
13. Any known food allergies: _____ Special Diet?: _____
14. Please list any medications the child is taking: _____
15. Any supplements?: _____
16. Please list any emotional/social/academic stressors in the child's life.
    _____
17. Main Concern(s) for Child:
    _____
    _____
    _____
18. Family History/What Runs in the Family?:
    _____
    _____
19. Lives with? (siblings?): _____

SPEECH ONLY SECTION:

1. Does your child have difficulty understand things you say to them? (receptive communication)_____

2. Does your child have difficulty using language to communicate to you? (Expressive)_____

3. Does your child have difficulty with certain sounds when speaking? (Articulation)_____

4. Does your child have difficulty using language in social settings? (Pragmatics)_____

Parent/Guardian Signature: _____ Date: _____