Central Delaware Speech Language Pathology, Inc.

**Occupational Therapy Intake Form**

Date/Time_____Initials_____

Dover Office Lewes Office AM PM M T W TH

Child's Name_____DOB_____Age_____Gender_____

Parent's Name_____Home Phone Number_____

Address_____Cell Phone Number_____

City/State/Zip_____ Email Address_____

Emergency Contact _____Relationship_____Phone_____

Main Concerns (Why are they seeking OT services) *(check as many as needed)*:

__ Fine motor skills (handwriting, cutting, fasteners on clothes, etc.)

__ Sensory regulation issues (sensitivities, obsessions/compulsions)

__ Self-care (dressing, toileting, feeding, etc.)

__ Community safety (emergency situations, safety awareness, etc.)

__ Play skills/Behavior

__ Positioning (sitting upright, won't go on stomach, etc.)

__ Balance/Coordination

__ Feeding (eating skills, selective eating, textures)

__ Notes/Other information

Medical Diagnosis Relating to Concerns _____

Allergies _____

Pediatrician_____Referring Physician _____

OT Script/Referral Y N

Insurance Y N Private Pay

1.Company_____ Member ID_____Contact #_____

2.Company_____ Member ID_____Contact #_____

- OT Evaluation _____
- Developmental Evaluation _____
- Audiology Evaluation _____
- Clinical Documentation-Specialist-PCP _____
- IEP _____

Schedule For: Eval Therapy Other

Does the child currently receive OT services at school? _____

What school? _____

Goal areas (if parents know) _____
_____

Updated 4.8.25