



Occupational Therapy Intake Form

NEW CLIENT INFORMATION

Date:	Patient Name:	Gender: ☐ F ☐ M	DOB:	Age:
Person Completing Form:			Relationship:	

PREVIOUS SERVICES

Type of Service	Yes or No	Date(s)	Therapy Provider
Speech/Language Therapy	☐ Y ☐ N		
Occupational Therapy	☐ Y ☐ N		
Physical Therapy	☐ Y ☐ N		
Psychological/Behavioral/Counseling	☐ Y ☐ N		
Other Specialist:	☐ Y ☐ N		

DIAGNOSES (check all that apply)

- | | |
|---|--|
| ☐ Autism spectrum disorder (Asperger's Syndrome) | ☐ Cerebral Palsy |
| ☐ ADD/ADHD (Attention Deficit Disorder) | ☐ Genetic disorder |
| ☐ Sensory processing disorder or sensory integration dysfunction | ☐ Learning disability |
| ☐ Anxiety or emotional disorder(s) Specify: _____ | ☐ Down syndrome |
| ☐ Other Specify: _____ | ☐ Intellectual Disability |

Who provided the above diagnosis and what criteria that diagnosis was based on (i.e.: test scores, comprehensive clinical evaluation, genetic study, etc.):

CHILDHOOD ILLNESSES/PROBLEMS

Check all problems that apply to your child and provide details:

Diseases/Problems	Age	Comments
Problems requiring (PE) tests in ear		
Allergies		
Injuries/accidents		
Asthma/Wheezing		
Stomach problems		
Gastro-intestinal problems		
Seizures/Epilepsy		
Head injury		
Broken bones		
Other		
List all current medications:		

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Anthony S. Fauci

A red circular graphic with a gradient, appearing as a partial circle or a stylized 'C' shape, located to the right of the name bar.

Occupational Therapy Intake Form:

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https://crm.avenza.com/public/virtual-library/Documents/Ocr_Mei_Statistics_2_June_2013_Paper.pdf

Table of Contents Occupational Therapy Intake Form

1. Understanding the eBook Occupational Therapy Intake Form
 - The Rise of Digital Reading Occupational Therapy Intake Form
 - Advantages of eBooks Over Traditional Books
2. Identifying Occupational Therapy Intake Form
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Occupational Therapy Intake Form
 - User-Friendly Interface
4. Exploring eBook Recommendations from Occupational Therapy Intake Form
 - Personalized Recommendations
 - Occupational Therapy Intake Form User Reviews and Ratings
 - Occupational Therapy Intake Form and Bestseller Lists
5. Accessing Occupational Therapy Intake Form Free and Paid eBooks
 - Occupational Therapy Intake Form Public Domain eBooks
 - Occupational Therapy Intake Form eBook Subscription Services
 - Occupational Therapy Intake Form Budget-Friendly Options

6. Navigating Occupational Therapy Intake Form eBook Formats
 - ePub, PDF, MOBI, and More
 - Occupational Therapy Intake Form Compatibility with Devices
 - Occupational Therapy Intake Form Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Occupational Therapy Intake Form
 - Highlighting and Note-Taking Occupational Therapy Intake Form
 - Interactive Elements Occupational Therapy Intake Form
8. Staying Engaged with Occupational Therapy Intake Form
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Occupational Therapy Intake Form
9. Balancing eBooks and Physical Books Occupational Therapy Intake Form
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Occupational Therapy Intake Form
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Occupational Therapy Intake Form
 - Setting Reading Goals Occupational Therapy Intake Form
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Occupational Therapy Intake Form
 - Fact-Checking eBook Content of Occupational Therapy Intake Form
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements

- Interactive and Gamified eBooks

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