

**Occupational Therapy Department  
INTAKE & CONSENT FORM**

**PERSON COMPLETING THIS FORM**

Full Name:

Date:

Relationship to Child:

Email:

Phone:

Address:

City:

Zip Code:

**CHILD'S INFORMATION**

Childs Full Name:

Childs Nickname (if applicable):

Male Female

Child's Date of Birth:

Child's Current Grade:

Name of Child's Current School:

Current Diagnosis Related to Child (If applicable):

Child's Siblings (if applicable-name/sex/age):

Allergies/Reactions (if applicable) :

Medications (if applicable):

**MEDICAL HISTORY**

Childs Birth Weight:

Childs Birth Height:

Birth Complications?

Premature

Full Term

Post Mature

Were there any concerns during labor or birth?:

Type of Birth Delivery:

Did the child require any medical procedures before, during, or after birth? Please describe:

Has your child ever been hospitalized?

Please describe any pertinent information to your child's medical history.

**BACKGROUND INFORMATION**

What are your primary current concerns for your child?

How do you hope OT can help your child?

Is the child currently receiving any therapy services? Please list providers, if applicable.

**Developmental History**

Please indicate at what age each major milestone was reached:

Sitting up by self:

Crawling:

Walking:

First Word:

Undressed self:

Tied Shoes:

Toilet Trained:

Dressed Self:

Does your child wear glasses

Yes

No

Needs Testing

Are you concerned with the child's development?

General Development Comments

**SOCIAL HISTORY**

How would you describe your child's personality:

Please describe your child's concentration:

Describe how your child interacts with peers:

What activities does your child like to do:

Any difficulties with sleep?:

What makes your child smile and laugh?:

Any concerns with behaviors?:

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### **AUTHORIZATION AND CONSENT FOR EVALUATION**

Please initial the following statements

\_\_\_\_ I, the undersigned parent or legal guardian of the above-named child, hereby give my consent for an Occupational Therapy evaluation to be conducted by ATSU Occupational Therapy Department.

\_\_\_\_ I, give the ATSU OT Department permission to evaluate and I understand there will be written, oral and electronic communication between EVJCC and ATSU OT Department for the purpose of completing the evaluation.

### **PHOTO PERMISSION**

Please initial the following OPTIONAL statements:

\_\_\_\_ I give permission for photos/videos of my child to be used for the purpose of treatment, education, and documentation by the ATSU OT Department.

### **PURPOSE OF EVALUATION**

The purpose of this evaluation is to assess the child's functional abilities, motor skills, sensory processing, and developmental milestones **to determine their eligibility and appropriateness for Occupational Therapy services**. The evaluation will also help us design a customized treatment plan to address any identified concerns and to promote the child's overall well-being.

**The Occupational Therapy evaluation may involve the following procedures:**

- Review of medical and developmental history
- Interview with the parent/guardian to gather relevant information
- Observation of the child's play and activities
- Assessment of motor skills, fine motor coordination, and sensory processing abilities
- Standardized tests and assessment tools

**CONFIDENTIALITY AND PRIVACY**

All information obtained during the evaluation process will be kept confidential and will only be accessible to authorized personnel involved in the child's assessment and therapy. Personal identifying information will not be disclosed to any third party without the written consent of the parent/guardian except as required by law.

**VOLUNTARY PARTICIPATION**

Participation in this evaluation is entirely voluntary, and parents/guardians have the right to withdraw consent at any time without affecting the child's current or future access to services.

**BENEFITS AND RISKS:** The evaluation aims to identify areas where the child may require therapeutic intervention. There are minimal risks associated with the evaluation, which may include temporary emotional discomfort or fatigue during the assessment.

By signing this form, I acknowledge that I have read and understood the information provided, and I willingly give my consent for the Occupational Therapy evaluation of my child.

Printed Name:

Signature of Parent/Guardian:

Date:

**Thank you for entrusting ATSU OT Department with the care of your child.**

**If you have any questions or concerns or need further information,  
please do not hesitate to contact us.**

