Total Pediatric Therapy OCCUPATIONAL THERAPY

Patient Name_____ Age_____

Have you received occupational therapy treatments in the past? Yes / No

If so, please explain:

Do you have concerns or input for the following areas? If so, please detail in the provided area.

Occupational Areas of Development	Examples	Strengths or Concerns
Fine Motor	• Grasp • Hand Use • Tool-use (pencils, scissors)	
Self Help Skills	• Utensil use • Dressing • Managing fasteners (buttons, zippers)	
Sensory	Response to: • Sound, touch, textures, and movements	
Play Skills	• Interactions with peers or toys • Favorite play activity or toy	

What are your main goals for Occupational Therapy Intervention?

Patient or Personal Representative Signature **Date**