Yoga OT.com Child Intake Form

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Child's Name and Age_____School and Grade_____
Guardian's Names_____
Address, e-mail address and phone number_____

_____
Child's Pediatrician Name, address and phone number_____
Does your child have an IEP?

Please list any injuries, disabilites, disorders that your child has or has had in the past and state the date of the injury. Also list surgeries and dates.

_____ _____

_____ _____

Allergies? Food_____ Medication_____
Environment_____

What is your Child's daily food intake?

Does your child:

Have pain?	Yes	No
Get at least 8 hours of sleep?	Yes	No
Sleep through the night?	Yes	No
Get him/herself dressed?	Yes	No
Have bowel or bladder accidents?	Yes	No
Have sensitivity to texture/noise?	Yes	No
Wear glasses or hearing aid?	Yes	No
Hold a pen/pencil on his/her own?	Yes	No
Prefers quiet places, avoids crowds? Seeks self sensory experiences?	Yes	No
Have a change in behavior if schedule changes?	Yes	No
Learn better with auditory directions?	Yes	No
Learn better with visual directions?	Yes	No

What would you like for Yoga to do for your child? Please Explain.

_____
_____
_____

Is your child currently being seen by any other therapists?
How did you hear about YogaOT?

Signature and printed name of guardian/s

_____