Clever Bees
Paediatric Occupational Therapy

Intake Questionnaire

Family Information

Child's Name: _____ DOB: _____

Parent/Guardian Name(s): _____

Address: _____ Postcode: _____

Phone: _____ Parent email: _____

Reason for referral/Areas of concern:

☐ Occupational Therapy ☐ Behaviour Support

Diagnosis: _____

School/Early Childhood Centre

Name: _____ Phone: _____

Teacher/Primary Carer: _____ Days of Attendance:_____

Additional Information: _____

Has an OT/other health professionals provided services to your child? **Yes** ☐ **No** ☐

- **Can you please email a copy of any recent reports?**

Who is in the child's support team:

Referral:

Referrer:_____

Funding Source: ☐ NDIS – Participant No: _____

☐ Agency-Managed

☐ Self-Managed

☐ Plan Managed - contact email:

☐ Medicare -GP Care Plan ☐ Chronic Disease Management Pla

☐ Better Access to Mental Health Care

☐ Private Health ☐ Other: _____

How did you hear about Clever Bees: _____

Is an Assessment Report required (an additional fee may apply): _____

Are there any days/times which are not suitable for sessions for your child?

_____

Preferred Location for session: _____

Any preferences for therapist (eg gender, age, cultural background, life experiences)?

Do you wish to work with: ☐ Occupational Therapist ONLY

☐ Occupational Therapist, with an Occupational Therapy Assistant following an individualised program developed by the Occupational Therapist

Are there any cultural values or beliefs you would like Clever Bees to be aware of:

_____

Client Risk Assessment

Behaviour:

Medical:

Choking/diet/allergies:

Other: