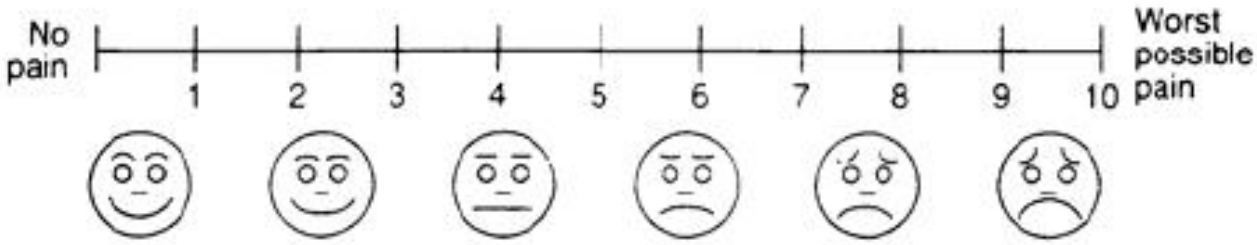
Intake Questionnaire

PLEASE BRING THIS WITH YOU FOR YOUR CHILD'S EVALUATION

Person Completing Questionnaire:	**Relationship to Child:**		
Child's Name: (First) (MI) (Last)			
Date of Birth:	**Age:**		
Male **Female**			
Address: (Street) (Apt)	City	State	Zip Code
Phone Number:			

Diagnosis:	
Allergies (Drug and food)**:**	**Medications** (Prescription and non-prescription)**:**

Referring Provider:



What are your primary concerns/Why did you bring your child in for an evaluation?

Family History:	
Caregiver #1 Name: **Age:**	**Caregiver #2 Name:** **Age:**
Relationship to Child:	**Relationship to Child:**
Caregiver preferred method of learning: Listening Reading Pictures Demonstration Other:_____	**Caregiver preferred method of learning:** Listening Reading Pictures Demonstration Other:_____
Biological Adopted Step-child Foster Other:_____	Biological Adopted Step-child Foster Other:_____
*** Language(s) Spoken in the Home:**	**Primary Language of Caregiver:**

Persons currently living in home environment:

Name_____Relationship_____Age_____
_
Name_____Relationship_____Age_____
_
Name_____Relationship_____Age_____
_
Name_____Relationship_____Age_____
_
Name_____Relationship_____Age_____
_
Name_____Relationship_____Age_____
_

Is there any family history of developmental, motor, social, or language delays or diagnoses? (If yes, please explain.)

CONTACT INFORMATION:
The following are the best contact numbers for me to most reliably be reached during business hours:

_____ _____
(Phone #1) (Phone #2)

EMERGENCY CONTACT: In case of an emergency, I hereby authorize only the following

persons to pick up my child:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Health Care Providers	
Primary Care Physician:	
Clinic Name:	**Clinic Phone Number:**

Birth History:	
Full Term **Prematurity at _____ weeks gestation**	
Single **Twin** **Triplet** **Other_____**	
Birth Weight:	**Birth Length:**
APGAR Scores: **1 min:_____** **5 min:_____** **10 min:_____**	
Maternal Health During Pregnancy: (check all that apply)	
No medical complications	Gestational diabetes
Hypertension	Bed rest
Drug/alcohol exposure	Medications:_____
Other:_____	
Labor: (check all that apply)	
Spontaneous without complications	Induced
C-section	Forceps and/or suction used
Other:_____	

Health of Infant at Birth: (check all that apply)	
No issues	Breathing difficulty
Jaundice	Brain bleed
Cardiac issues	Seizures
Gastroschisis	NAS-neonatal abstinence syndrome
Other:_____	Polyhydramnios

Health During Infancy: (check all that apply)	
Relatively healthy	Respiratory infections
Reflux	Recurrent ear infections

Feeding difficulties	Inconsolable, frequent crying
Hernia	Other:_____

Current Overall Medical Health: (please explain).

Good Fair Poor

Hearing:

Any concerns with child's hearing?

Yes No

Explain:

History of ear infections?	Date and results of most recent hearing screen:
Yes No	

Vision:

Any concerns with child's vision?	Date and results of most recent vision screen:
Yes No Explain:	

Has your child ever had problems with (check all that apply):

	Explain	Onset Date
Allergies		
Heart		
Kidney/Urinary		
Respiratory		
Liver		
Cranial Bleed		
Hydrocephalus		
Shunt		
Seizures		
Skin Reactions		
Memory/Cognition		
Pneumonia		
Dietary Restrictions		
Reflux		
Weight Loss/Gains		
Intrauterine drug exposure		

Other_____		

Diagnostic Tests: (MRI, EEG,CUS, X-ray, etc.)		
Test	**Date**	**Results**

Specialists: (check all that apply)	Name of Specialist(s)	Phone Number	Date(s) of Service
Neurologist			
Psychologist/psychiatrist			
Orthopedist			
ENT (Ear, Nose, and Throat)			
Allergist			
Optometrist/ophthalmologist			
Cardiologist			
GI (Gastroenterologist)			
Other:_____			

Current and Previous Therapies: (OT/PT/SLP etc.)		
Name of Provider(s)	**Clinic Name**	**Date(s) of Service**

History of Surgeries, Major Injuries, Illnesses, and Hospitalizations:
Date/Reason:
Date/Reason:
Date/Reason:
Date/Reason:

Date/Reason:

School/Academic Information:	
School currently attending:	
Grade:	Age at which began school:
Does your child currently receive any of the following services: (check all that apply) Special education Special testing In school therapy (speech, occupational, or physical)	
Has your child been evaluated for school based therapy services: Yes **Date of evaluation(s):_____** No ***IF YES, PLEASE BRING A COPY WITH YOU TO THE EVALUATION.**	
Does your child have an IEP/IFSP? Yes No ***IF YES, PLEASE BRING A COPY WITH YOU TO THE EVALUATION.**	

Gross Motor Skills/Milestones: (please indicate **AGE** at which child reached milestone)
Rolled:
Sat:
Crawled:
Pulled to stand:
Stood:
Cruised:
Walked:
Ran:

Fine Motor Skills: (please check yes or no for each statement)		
My child is able to reach for toys.	Yes	No
My child is able to bang toys together in play.	Yes	No
My child is able to pick up small items (i.e. Cheerios).	Yes	No
My child is able to scribble.	Yes	No
My child is able to write his/her name.	Yes	No
My child is able to snip with scissors.	Yes	No
My child is able to draw a stick figure of a person.	Yes	No

Self-Care Skills: (please check yes or no for each statement)		
My child is able to dress him/herself independently (not including clothing fasteners).	Yes	No
My child is able to feed him/herself independently using a spoon.	Yes	No
My child is able to feed him/herself independently using a fork.	Yes	No
My child is able to drink from an open-cup or from a straw.	Yes	No
My child is able to bathe him/herself independently with only verbal reminders.	Yes	No
My child is toilet trained. Age potty trained_____	Yes	No

Sleep: (please check yes or no for each statement)		
My child sleeps independently in his/her own bed/crib.	Yes	No
My child is able to easily fall asleep at night and for naps.	Yes	No
My child is able to sleep through the night without waking.	Yes	No # of times wakes _____
My child snores and/or has a history of sleep apnea.	Yes	No

Sensory: (please check yes or no for each statement)		
My child dislikes being messy.	Yes	No
My child is a “picky eater”.	Yes	No
My child seems to constantly be “on the go”, having difficulty sitting still.	Yes	No
My child becomes upset with brushing teeth/hair, bathing, dressing/undressing.	Yes	No
My child “melts-down” when there is a change in routine, or something unplanned comes up.	Yes	No
My child becomes easily frustrated and frequently has tantrums.	Yes	No
My child appears not to “tune-in” to what I say, even though his/her hearing is fine.	Yes	No

Feeding: (please check yes or no for each statement)		
My child consumes liquids via breast/bottle.	Yes	No
My child receives nutrition via feeding tube.	Yes	No
My child coughs/chokes/gags when eating.	Yes	No
My child easily transitioned to solid foods.	Yes	No
My child appears to chew his/her food thoroughly.	Yes	No

Language Milestones: (please indicate **AGE** at which child reached milestone)
First word:
Began 2-word utterances (e.g. “mommy up”):

Understanding Language:
When you talk to your child, how much does he or she understand? **Check one**:

A few words	Simple directions
Many words and phrases	Almost everything I say

Additional comments/examples:

Communicating 1:
How does your child let you know what he or she wants? **Check ALL that apply**:

Cries	Uses a few words
Points to what he or she wants	Says many words, but only one at a time
Uses gestures	Says two or three word sentences
Makes a few sounds	Uses long sentences
Makes many different sounds	

Additional comments/examples:

Communicating 2: (please check yes or no for each statement)		
My child answers when I talk to him or her.	Yes	No
My child talks about what he or she is doing.	Yes	No
Family members can understand my child’s speech.	Yes	No
People outside of the family can understand my child’s speech.	Yes	No

Information I need in order to help my child:
I would like to have more information about… **Check ALL that apply**:

Child development	Family support groups
Diagnoses and treatment	Respite care
Laws governing services for children	Other treatment options
Early intervention services (birth-3 years)	Special education services
Financial assistance (e.g. insurance, SSI, Medicaid)	
Other: _____	

I acknowledge that I have received a copy of the *Welcome to Pediatric Therapy Services* orientation packet.

Caregiver Signature:_____ Date:_____