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General 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** ☐			
Primary language in home:			
Address: (Street) (Apt)	City	State	Zip Code

Phone Number: *Best contact numbers to be reached at 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_____

Diagnosis:

Referring Provider:

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

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

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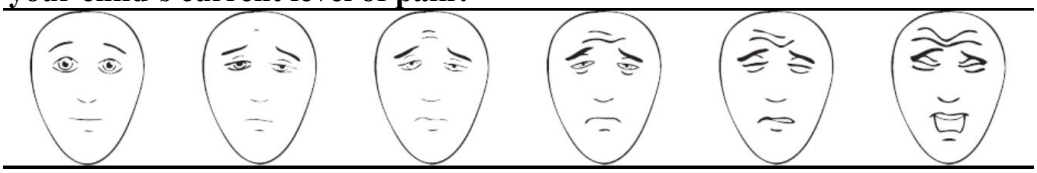
What is your child's current level of pain?



Last PHYSICAL EXAM:
Month : Year:
Doctor: Results:

Last VISION TEST:
Month : Year:
Doctor: Results:
Does your child wear glasses?
☐ Yes ☐ No Since When:

Last HEARING TEST:
Month : Year:
Doctor: Results:
Did/does your child wear a hearing aid?
☐ Yes ☐ No Since When:

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

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

Has your child ever had problems with (check all that apply):	**Explain**	**Resolved**	**Unresolved**
☐ Allergies			

☐ Cranial bleed			
☐ Dietary restrictions			
☐ Heart			
☐ Hydrocephalus			
☐ Intrauterine drug exposure			
☐ Kidney/urinary (e.g. UTI)			
☐ Liver			
☐ Memory/cognition			
☐ Reflux			
☐ Respiratory (e.g. asthma, pneumonia, RSV, supplemental O2)			
☐ Seizures			
☐ Shunt			
☐ Skin reactions			
☐ Weight loss/gain			
☐ 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**
☐ Allergist			
☐ Autism Clinic			
☐ Cardiologist			
☐ Craniofacial Clinic			
☐ Dietician			
☐ ENT (Ear, Nose, and Throat)			
☐ GI (Gastroenterologist)			

☐Nephrologist/urologist			
☐Neurologist			
☐Optometrist/ophthalmologist			
☐Orthopedist			
☐Psychologist/psychiatrist			
☐Other:_____			

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

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:**

Other persons currently living in home environment:

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.)

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

Caregiver Signature:_____ Date:_____