# INTAKE FORM

Date:_____
Type of Evaluation Scheduled:_____ OT_____PT _____ST

## Patient Information:

Patient Name: (Last/First MI) _____

Date Of Birth: _____ / _____ / _____ Age:_____

Primary Language Spoken: _____

School Attended:_____ Grade _____

Medical Diagnoses: _____

Educational Diagnosis:_____

Allergies: _____yes ____no ____unknown

Please describe_____

Medications: _____yes ____no ____unknown

Please describe_____

Precautions/Contraindication: _____yes ____no ____unknown

Please describe_____

Dietary Restrictions: _____yes ____no ____unknown

Please describe_____

Parent/Legal Guardian name/s:_____

Siblings Name/s and Age/s:_____

Sibling diagnosis and current services if applicable:_____

Who currently lives with this child?_____

## Reason for Evaluation:

Parental concerns: _____

_____

_____

Goals for therapy:_____

_____

_____

## Outside Resource Information:

Does or has your child received out-patient Speech (ST), Occupational (OT), or Physical Therapy (PT)? ____yes ____no

Does or has your child been on an IFSP, IEP, 504? ____yes ____no

If yes, what services do they currently receive in school? ___OT ___PT ___ST

Has your child received cognitive/intelligence/psychological testing? ___yes ___no

Results: _____

Has your child received a hearing screen or formal hearing evaluation? ___yes ___no

Results: _____

Has your child received a vision screen or formal vision evaluation? ___yes ___no

Results: _____

*If you have the results of these evaluations, please provide to the evaluating therapist or enclose with your intake paperwork.*

## Birth and Development History:

Delivery Method:

__Planned C-Section __Forceps/Suction __Unknown

__Vaginal __Emergency C-Section

Were there any issues with the pregnancy and delivery of your child? ___yes ___no

Please Describe:_____

_____

Were there any feeding difficulties after birth including problems with suckling or nutrient intake?

___yes ___no

Please Describe:_____

Was your child tongue tied? ___yes ___no

Does your child experience frequent ear infections? ___yes ___no

Does your child have P.E. tubes? ___yes ___no

Check all that apply: ___ Permanent ___ Temporary ___Left Ear ___Right Ear ___Both Ears

Has your child had any significant childhood illnesses? ___yes __no

Please Describe_____

Does your child use any adaptive equipment? ___yes ___no

Please Describe:_____

Do you have feeding or eating concerns? ___yes ___no

Please Describe:_____

| **Developmental History:** Did your child reach developmental milestones at appropriate times? (if no, specify age milestone was met) | YES | NO | AGE |
|---|---|---|---|
| Babble (4-6 months) | | | |
| Roll (5-6 months) | | | |
| Sit independently (6-8 months) | | | |
| Crawl (9-11 months) | | | |
| Walk (12-15 months) | | | |
| First Word (12 months) | | | |
| 2-3 word sentences (18 months) | | | |
| Drink from a cup independently (12-16 months) | | | |
| Feed self independently (2 ½ - 3 years) | | | |

| | | | |
|---|---|---|---|
| What type of utensils? | | | |
| **Behavior/Temperament:**<br>Describe your child at present: | YES | NO | COMMENTS |
| Mostly quiet, calm, patient | | | |
| Hyperactive, always in motion | | | |
| Rigid, set in his/her ways | | | |
| Upset by transitions/unexpected changes | | | |
| Short attention span | | | |
| Impulsive | | | |
| Over reacts | | | |
| Exhibits frequent temper tantrums | | | |
| Has difficulty separating from primary caretaker | | | |
| Has nervous habits or tics | | | |
| Regular sleep patterns | | | |
| Difficult to get to sleep | | | |
| Is frustrated easily | | | |
| Has unusual fears | | | |
| Has a difficult time in public places | | | |
| Very cautious with trying new things | | | |
| Has poor safety awareness | | | |
| Play with toys differently than peers | | | |
| **Vision:** | YES | NO | COMMENTS |
| Rubs eyes while playing or working | | | |
| Poor reading comprehension | | | |
| Eyes are tired at the end of the day | | | |
| Trouble copying from the board | | | |
| Holds things very close to eyes | | | |
| Complains of eyestrain, headaches | | | |
| Makes reversals when copying or reading | | | |

| | | | |
|---|---|---|---|
| **Communication:**<br>Do you have any concerns regarding your child's speech and/or language? | YES | NO | COMMENTS |
| Does your child make their needs and wants known? | | | |
| Does your child communicate differently than others their age? | | | |
| Was there a specific timeline when the change occurred? | | | |
| Did something occur that brought about this change? | | | |
| Is their speech understandable/intelligible to others | | | |
| Is their speech understandable/intelligible to family members | | | |
| Use a loud voice | | | |
| Use a monotone voice | | | |
| Have hoarse voice | | | |
| **Motor:** | YES | NO | COMMENTS |
| Gets tired easily playing | | | |
| Seems generally weak compared to peers | | | |
| Has difficulty playing on playground equipment | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Seems clumsy, awkward | | | | | | | |
| Has poor ball skills (catching, dribbling) | | | | | | | |
| Has difficulty with stairs | | | | | | | |
| Has poor balance | | | | | | | |
| Has difficulty jumping | | | | | | | |
| Has difficulty playing on playground equipment | | | | | | | |
| **Functional Status:** | | | If you answer no to any questions, please state how much assistance is needed? | | | | |
| | YES | NO | Depend/100% | Max/75% | Mod/50% | Min/25% | Min/10% |
| Independent with dressing | | | | | | | |
| Independent with toileting | | | | | | | |
| Independent with bathing/showering | | | | | | | |
| Independent with grooming (brush teeth, comb hair, wash face) | | | | | | | |
| Independent with feeding | | | | | | | |
| Can independently fix a snack | | | | | | | |

## Additional Questions:

What does your child like to do?

What does your child dislike?

Is your child currently active in any extracurricular/recreational activities? ____yes ____no

Please Describe_____

Any additional comments or concerns you would like to share?