Intake Questionnaire

Name:_____ Date of Birth:_____ Gender:_____

Address:_____

Parent/Guardian Name:_____ Relationship to Child:_____

Address:_____

E-Mail:_____ Phone:_____ (cell) (home)

Referred by:_____

Specialty Physician(s) (i.e. allergist, psychiatrist, etc.)

Name:_____ Phone:_____ Fax:_____

Last seen:_____ How often seen:_____

Name:_____ Phone:_____ Fax:_____

Last seen:_____ How often seen:_____

Name:_____ Phone:_____ Fax:_____

Last seen:_____ How often seen:_____

Current Therapy

Please provide all current therapy information to the best of your knowledge. Please write N/A if the therapy listed does not apply to your child.

	Therapist's Name	Setting	Phone #	Dates of Services
Occupational				
Physical				
Speech				

Mental Health				
Social/Play Group				

**Please include the name of the clinic, company or organization, under the Setting's column.*

Past Therapy

Please provide previous therapy history, to the best of your knowledge. If the therapy listed, does not apply to your child, please write N/A in the specified box.

	Therapist's Name	Setting	Phone #	Dates of Services
Occupational				
Physical				
Speech				
Mental Health				
Social/Play Group				

**Please include the name of the clinic, company or organization, under the Setting's column.*

Birth History

Were any medications taken during pregnancy?_____

Drugs or Anesthetics during labor?_____

Type of delivery:_____
Any complications during pregnancy?_____

Complications during delivery?_____

Length of pregnancy:_____ Length of Labor:_____

Birth Weight:_____ APGAR Score:_____ Adopted: Yes / No

Age of adoption (if applicable):_____ Birth Country:_____

Length of hospital stay:_____ NICU: Yes/NO

Equipment at discharge (NG tube, oxygen, shunt, etc.):_____

Did you experience any difficulties immediately following birth?
Please circle any and all that apply

Breathing Unusual Muscle Tone

Jaundice Bleeding/Stroke

Scars/Bruising Head Injury

Other:_____

Health and Medical History

Please describe any special medical concerns and/or precautions (cardiac, nutrition, etc.):

_____

_____

Please list any current medications:

_____

_____

Seizures: Yes / No

Age of first Seizure:_____ Age of last seizure:_____

Current Treatment:_____

Vision History

Ophthalmologist evaluation: Yes / No If yes, date of evaluation:_____

Results of evaluation:_____

Optometrist Evaluation: Yes / No If yes, date of evaluation:_____

Results:_____

Glasses: Yes / No Nearsighted or Farsighted

Developmental Optometrist: Yes / No If yes, date of evaluation:_____

Results:_____

Does your child demonstrate or have a history of the following:

Strabismus Rubbing eyes

Eyes turning in/out Focus on rotating objects

Difficulty maintaining eye contact

Hearing History

Please describe ear health history. Include frequent infections, tubes and hearing test results:

_____

_____

_____

Assistive hearing devices: Yes / No If yes, please describe:_____

Developmental History

Please indicate the approximate age of the gross motor function listed below:

Head held erect:_____ Alone without support: _____

Rolled over: _____ Crawled: _____

Pulled to stand: _____ Walked alone: _____

Rode a tricycle: _____ Rode a Bicycle: _____

Please circle all that apply.

Does your child:

Fall or lose balance easily	Trips often
Alternate feet when going upstairs	Alternate feet when going downstairs
Walk up/down stairs w/o support	Catch a ball
Run smoothly	Jump

Please describe the positions your child spend the most time in, when at home. For example, leaning on a table/objects or on their stomachs or backs):

_____

_____

What are your greatest concerns regarding your child's gross motor skills?

_____

_____

_____

Please list the approximate age your child first experienced the fine motor and sensory motor function listed below:

Follow objects with his/her eyes:_____ Brought hands together:_____

Reached for objects:_____ Ate alone with a spoon:_____

Please describe particular items and textures that your child dislikes touching:

_____

_____

Did your child mouth objects as a baby? Yes / No

Does your child have a hand preference? Yes / No Right / Left

Does your child consistently use one hand for a specific task and the other for another task? Yes / No

Which hand does your child use for:

Eating: Right / Left / No preference

Throwing: Right / Left / No preference

Writing: Right / Left / No preference

Does your child enjoy fine motor activities such as art projects, coloring and/or writing? Yes / No

What are your greatest concerns about your child's fine motor skills?

_____

_____

_____

How much help does your child need with the following?

(1 independent, 2 minimal help, 3 maximum help, 4 unable)

Putting on a coat: _____ Putting on a dress: _____

Putting on pants: _____ Putting on a shirt: _____

Putting on socks: _____ Putting on underwear: _____

Removing a coat: _____ Removing a dress: _____

Removing pants: _____ Removing a shirt: _____

Removing socks: _____ Removing underwear: _____

Buttoning: _____ Unbuttoning: _____

Zipping: _____

Unzipping: _____

Tying a knot: _____

Typing a bow: _____

Untying a knot: _____

Untying a bow: _____

Bathing self: _____

Blowing nose: _____

Brushing teeth: _____

Combing hair: _____

Washing hands: _____

Cutting food w/ a knife: _____

Drinking from a cup: _____

Holding a cup: _____

Using a spoon: _____
(with a mature grasp)

Using a fork: _____
(with a mature grasp)

Describe your child's attention during the sitting activity listed below. Please include duration: (poor, fair, good, excellent)

Watching T.V._____

Reading or looking at pictures:_____

Listening to a story:_____

Speech and Language History

Does your child have any speech and language difficulties? Yes / No

If yes, please describe:

_____

_____

Has your child ever had a speech evaluation? Yes / No

If yes, please list when and where, as well as any results:

_____

_____

Language(s) spoken at home:_____

Social Emotional and Behavioral History

What do you like most about your child? _____

_____

_____

What worries you most about your child? _____

_____

_____

How does your child calm himself/herself when upset?

_____

_____

Does your child have meltdowns or temper tantrums? Yes / No

How often?_____ How long do they last? _____

What tends to be the precursor? _____

Does your child's behavior change in group settings? Yes / No

If so, please describe: _____

_____

_____

Does your child actively seek social situations? Yes / No

Comments:_____

Does your child actively avoid social situations? Yes / No

Comments:_____

Does your child have opportunities to interact with peers? Yes / No

Comments:_____

Does your child have difficulty with transitions between people or environments? Yes / No

Comments:_____

Describe your child's communication abilities with peers: _____

_____

_____

Describe activities your child enjoys? _____

_____

Does your child need support to complete homework, often needing breaks, food, music or extended time? _____

_____

Does your child have difficulty keeping track of organizing personal belongings? Yes / No

Balance, Body Awareness and Praxis

Does your child initiate new activities? Yes / No

Does your child understand how to play with new toys? Yes / No

Can your child play with toys in a variety of ways? Yes / No

Is your child able to perform sequential tasks? Yes / No

Can your child jump? Yes / No

Does your child play on playground equipment? Yes / No

Does your child enjoy rough-house type of play? Yes / No

Does your child take risks? Yes / No

Does your child have good safety awareness? Yes / No