Intake Information:

Date of form completion________________________

Patient Information:

Child's full name: ___________________________________Date of Birth: _________ Age: _________ Sex: _________

Nickname: _____________________Address: _________________________________ City: __________________________

State:___________ Zip:___________________ Phone Number:_____________________________ Cell Landline

SSN____________________________________

Additional information regarding care, contact, and restrictions:

____

Guardian Information:

Guardian's Name (1): ____ Relationship: ___________________________

Address: _______________________________________ City: ____________________ State:________ Zip: ____________

Home Phone: ___________________________________Cell Phone:____

E-mail:____

If applicable: Guardian's Name (2): ________________________________ Relationship: _______________________

Address: _______________________________________ City: ____________________ State:________ Zip: ____________

Home Phone: ___________________________________Cell Phone:____

E-mail:____

Emergency Contact: _____________________________ Phone__________________ Relationship: ________________

Doctor's Information:

Physician/Pediatrician (Name and Facility): ____

Physician's Phone number: ____

Insurance Information:

Primary Insurance: ______________________________ Secondary Insurance:_______________________________

Primary Insured Name: ___________________________ Relationship to patient:_____________________________

Primary Insured Date of Birth:_____________________ Primary Insured SSN:______________________________

Signature of Parent or Legal Guardian____

Name of Parent or Legal Guardian____

Patient Health Summary:

Date of form completion________________________

Birth History:

Child was born: full-term premature; If premature, how many weeks? ___________________________

Delivery: Vaginal With forceps C-section

Was your child placed in the Newborn Intensive Care Unit (NICU)? No Yes, how long?_______________

Please describe any other medical problems or complications at birth:

____

____

Medical History:

Current Diagnosis: ____

Hospitalizations (include dates): ____

Surgical Procedures (include dates): ____

Medications: ____

Allergies: ____

Special Equipment: ____

Nutritional Concerns: ____

Complaints of pain:____

Developmental History:

Current physical limitations: ____

Caregiver concerns: ____

Child's strengths: ____

Prior History of Therapy (PT, OT, Speech, or ABA): ______________________________________

Please indicate at what age your child achieved the following milestones: Please Mark N/A for those which your child cannot complete:

Rolled Over___________
Babbled_______________
Sat alone______________
Said first word_________
Crawled__________________
Drank from a cup_________
Pulled to Stand ___________
Used a spoon_____________
Toilet trained__________
Walked alone__________
Dressed Self___________

Educational Information:

School/Educational program currently attending: ________________________________ Grade:_____________

Services received in school: Physical Therapy Occupational Therapy Speech Therapy Special Education Behavior Intervention Other Special Service _________________________________

Does your child's teacher have concerns? ____

Social/Emotional Development & Behaviors:

Does your child interact well with others? ____

Does your child have difficulty making friends? ____

Does your child have difficulty calming themselves when upset? ____

Additional comments: ____

Please check any of the following that apply to your child:

- Cries often
- Trouble following directions
- Frequent Temper tantrums
- Dislikes touch from others
- Clumsy
- Dislikes playground equipment
- Trouble with changes in routine
- Constantly moving
- Rocks self
- Weak muscles
- Sensitive to light
- Sensitive to sound
- Picky Eater
- Mouths objects
- Poor attention span

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

Patient's Name: ____

Parent/Guardian Name: ____Relationship:___________________

Parent/Guardian Signature: ____Date Signed: ___________________