**Patient Intake Information**

Services needed (circle) Occupational Therapy Speech Therapy

Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Age: \_\_\_\_\_\_\_\_\_\_\_\_ Patient Gender: \_\_\_\_\_\_ Language Spoken at Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parents/Guardian Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parents Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Subscriber date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is the patient attending school: \_\_\_\_\_\_\_ If Yes, Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_ List of siblings and others who reside in same home as patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is there any religious beliefs we should know about that could impact therapy or activities: \_\_\_\_\_\_\_\_\_\_ Is the patient on a specific diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s favorite activities, food and cartoons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the patient currently participate in activities such as sports or church functions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s form of mobility (circle): Crawl Walk Wheelchair How does the patient communicate (circle): Gestures Single Words Short Phrases Sentences

Does the patient have difficulty keeping up with friends: \_\_\_\_\_\_\_\_\_\_\_\_ If yes describe: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Briefly describe the reason for the therapy evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was concern or problem first identified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has there been previous therapy treatment: \_\_\_\_ If yes, where and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient and/or family concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Describe what you want your child to achieve with help of therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were there any complications during pregnancy or delivery: \_\_\_\_\_\_\_ If yes describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vaginal or Cesarean delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was your child full term: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If premature, how many weeks gestation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was your child in NICU: \_\_\_\_\_\_\_\_ If yes, how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apgar score: \_\_\_\_\_\_\_ Does the patient see any specialist providers such as neurologist or psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the patient respond to: Light? Yes No People? Yes No Sound? Yes No Textures? Yes No

Is the patient left-handed, right-handed or undetermined: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Question: | Yes | No | If yes, describe  |
| Infection or illness during pregnancy |  |  |  |
| Any shocks or abnormal stress during pregnancy |  |  |  |
| Did mothers water break 24 hours before delivery |  |  |  |
| Did mother develop toxemia or high blood pressure |  |  |  |
| Any prenatal complications |  |  |  |
| Breech |  |  |  |
| Cord wrapped around neck |  |  |  |
| Required forceps |  |  |  |
| Birth injuries |  |  |  |
| Cried immediately  |  |  |  |
| Infections at birth |  |  |  |
| Surgery at birth |  |  |  |
| Jaundice |  |  |  |
| Apgar score |  |  |  |
| Was child hospitalized after birth or any problems after birth |  |  |  |

**Prenatal/Perinatal History**

**Medical Questionnaire**

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Yes | No | Explanation |
| Frequent colds |  |  |  |
| Frequent strep, sore throat |  |  |  |
| Frequent ear infections |  |  |  |
| Birth defect, genetic disorder |  |  |  |
| Asthma |  |  |  |
| Heart condition |  |  |  |
| Visual disorder |  |  |  |
| Neurological disorder |  |  |  |
| Seizures or convulsions |  |  |  |
| Hearing loss |  |  |  |
| Head injuries |  |  |  |
| Major medical illness |  |  |  |
| Hospitalizations or surgeries |  |  |  |
| Dental problems |  |  |  |
| Does your child let you brush their teeth |  |  |  |
| Respiratory problems |  |  |  |
| List of current medications |  |  |  |
| Medication allergies |  |  |  |
| Receive any supplemental feeding |  |  |  |
| Does your child exhibit behavior issues during meals |  |  |  |
| Does your child use special equipment to eat |  |  |  |
| Difficulties with feeding, sucking, swallowing, drooling, chewing, reflux, or choking |  |  |  |
| Any other medical diagnosis or concerns  |  |  |  |

|  |  |
| --- | --- |
| **Milestone** | **Age in months** |
| Child breast fed? How long? Age stopped? |  |
| Held a bottle |  |
| Held a cup with a spout |  |
| Held a regular cup |  |

Is there a family history of any of the following? (Parents, siblings): Reading or learning difficulties \_\_\_ Hearing loss \_\_\_ Cleft Palates \_\_\_ Speech problem\_\_\_ Seizure Disorder\_\_\_ Prematurity \_\_\_ Mental Illness \_\_\_ Language delay\_\_\_ Alcoholism \_\_\_ Drug use \_\_\_ ADD/ADHD \_\_\_

Printed Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_