"The Right Choice" for therapy services in Texoma for over 70 years

PEDIATRIC INTAKE FORM

Child's Name:	Child's Date of Birth:	Male/Female:
Mother's Name:	Father's Name:	
Does your child live with both parents? ☐ Yes ☐ No If no, please briefly explain the circumstances.		
Please list names and ages of siblings (brothers and sisters and put an * beside those that live with the client).		
Child's Primary Physician: When was last visit?	Child's Referring Physician: When was last visit?	
Diagnosis:	What languages are spoken in the home? ☐ English ☐ Spanish ☐ Other _____ What is the primary language spoken?_____	
Where and with whom does your child spend most of his/her time?		
What are your child's interests (favorite toys, activities, etc.)?		
Who is present for this evaluation and their relationship to the child?		

THERAPY INFORMATION

What are your primary areas of concern for your child?
What are your goals for therapy?
Please list any previous OT/PT/ST evaluations and/or services your child has received and the dates:

MEDICAL HISTORY

Has your child had any of the following?		
☐ Asthma	☐ Chicken pox	☐ Frequent colds
☐ Croup	☐ Dizziness	☐ Draining ear
☐ Ear Infections	☐ Encephalitis	☐ German measles
☐ Mastoiditis	☐ Measles/Mumps	☐ Meningitis
☐ Compromised immune system	☐ Pneumonia	☐ Reflux
☐ Tonsillitis	☐ Sinusitis	☐ Tinnitus
☐ Seizures	☐ Sleeping difficulties	☐ Cardiac issues
☐ Weight change (loss or gain)	☐ Torticollis	☐ Neurological issues
☐ Pain	☐ Other:	

Has your child been seen by any other specialists (audiologists, psychologists, special education teachers, dentists, neurologists, or specialty clinics, etc.)? ☐ Yes ☐ No
If yes, please indicate the type of specialist, when your child was seen, and the specialist's conclusions or suggestions.

Has your child had any surgeries (e.g. tonsillectomy, PE tubes, feeding tube placement)? ☐ Yes ☐ No
If yes, what type and when?

Has your child had any major accidents or hospitalizations? ☐ Yes ☐ No
If yes, please explain.

Is your child taking any medications? ☐ Yes ☐ No
If yes, please list.

Has there been any negative reactions to medications? ☐ Yes ☐ No
If yes, please identify.

Does your child have any food, drug or environmental allergies? ☐ Yes ☐ No
If yes, please describe.

Is there a family history of speech, language, hearing, developmental, or behavioral/psychological problems? ☐ Yes ☐ No
If yes, please describe.

Does your child have any medical precautions (i.e. fall, allergy, fall)? ☐ Yes ☐ No
If yes, please describe.

Check all special equipment that your child has that is still appropriate:
☐ Wheelchair ☐ Walker ☐ Crutches ☐ Braces/AFO's/Orthotics
☐ Communication Device ☐ Hearing aides
☐ Eye glasses/last exam: _____ ☐ Other:

PRENATAL AND BIRTH HISTORY

Mother's general health during pregnancy (illnesses, accidents, medications, etc.):	
Length of pregnancy: _____ weeks	☐ Full Term ☐ Premature
Birth weight: _____	Type of delivery: ☐ Vaginal ☐ Caesarian
Please describe any complications that occurred during and after your child's birth (e.g. NICU stay, use of oxygen, feeding problems):	

DEVELOPMENTAL HISTORY

Provide the approximate age at which your child began to do the following activities:			
Crawl _____	Sit _____	Walk _____	Feed self _____
Dress self _____	Use toilet _____		
Ride a bike with training wheels _____ without training wheels _____			
Use single words (e.g. no, mom, doggie) _____		Combine words (e.g. me go, daddy shoe)_____	
Engage in conversation_____			
Approximately how many words did you child have at 18 months? _____ 24 months _____			
Does your child have difficulty walking, running, or participating in other activities that require small or large muscle coordination? ☐ Yes ☐ No If yes, please explain.			

ACADEMIC INFORMATION

School/Daycare Attended:	Grade:	Teacher:	
Concerns Noted:			
I feel my child does well in school.	☐ Yes ☐ No	My child takes a long time to do his/her work.	☐ Yes ☐ No
My child is challenged with reading.	☐ Yes ☐ No	My child has trouble concentrating.	☐ Yes ☐ No
My child is challenged with writing.	☐ Yes ☐ No	My child has difficulty communicating with teacher and peers.	☐ Yes ☐ No
My child is challenged with math.	☐ Yes ☐ No	My child has an IEP.	☐ Yes ☐ No
My child has trouble getting around physically on the school grounds.	☐ Yes ☐ No	Please explain what accommodations your child receives in his/her IEP.	

SOCIAL/BEHAVIOR HISTORY

How does your child interact with others? ☐ Easy going ☐ Shy ☐ Uncooperative ☐ Assertive ☐ Aggressive ☐ Other:		
Does your child play appropriately with age level peers? ☐ Yes ☐ No		
Does your child play with toys appropriately for his/her age? ☐ Yes ☐ No		
Please check all that apply to your child:		
☐ Is social and engaging	☐ Does well with change	☐ Has difficulty paying attention
☐ Unable to self-calm	☐ Is aggressive	☐ Extremely sensitive to criticism
☐ Has difficulty listening	☐ Is very busy and active	☐ Has difficulty with transitions
☐ Prefers to play alone	☐ Has tantrums	☐ Plays well on playground equipment
☐ Is well behaved	☐ Pays attention	☐ Makes good eye contact
☐ Makes good eye contact	☐ Appears clumsy	☐ Disregards for safety for self or others
☐ Takes turns with peers	☐ Listens well	☐ Does not like crowds
☐ Is easy going	☐ Does not like new places/people	☐ Quickly escalates without apparent cause

ACTIVITIES OF DAILY LIVING

How well does your child dress him/her self?	☐ Independent ☐ Needs verbal cues ☐ Needs some physical help ☐ Needs someone to do it for him/her
How well does your child tie his/her shoes?	☐ Independent ☐ Needs verbal cues ☐ Needs some physical help ☐ Needs someone to do it for him/her
How well does your child perform buttons/zippers?	☐ Independent ☐ Needs verbal cues ☐ Needs some physical help ☐ Needs someone to do it for him/her
How well does your child perform bathing?	☐ Independent ☐ Needs verbal cues ☐ Needs some physical help ☐ Needs someone to do it for him/her
How well does your child perform grooming tasks?	☐ Independent ☐ Needs verbal cues ☐ Needs some physical help ☐ Needs someone to do it for him/her
How well does your child feed him/her self?	☐ Independent ☐ Needs verbal cues ☐ Needs some physical help ☐ Needs someone to do it for him/her
How well does your child perform toileting?	☐ Independent ☐ Needs verbal cues ☐ Needs some physical help ☐ Needs someone to do it for him/her
How well does your child sleep at night?	☐ No problem ☐ Has trouble staying asleep ☐ Has trouble going to sleep ☐ Co-sleeps Please explain:
How well does your child complete his/her chores?	☐ Independent ☐ Needs verbal cues ☐ Needs some physical help ☐ Needs someone to do it for him/her
How many hours of “screen” time does your child participate in a day? (i.e. phone, tablet, television, computer) ____	

SPEECH-LANGUAGE-HEARING

What concerns do you have about your child's speech/language skills? *Check all that apply*

☐ Not talking much or at all	☐ Not speaking in sentences	☐ Stuttering
☐ Difficult saying certain sounds	☐ Does not seem to understand what is said to him/her	☐ Cannot understand what he/she says
☐ Voice quality	☐ Other	

When were these concerns first noticed? By whom?

Has the concern changed since it was first noticed? ☐ Yes ☐ No
If yes, please explain.

Is your child aware of his/her difficulties? ☐ Yes ☐ No
If yes, how does he/she feel about it?

Has your child previously had a speech screening/evaluation by a speech-language pathologist?
☐ Yes ☐ No
If yes, by whom and when?

What were their conclusions or suggestions?

How does your child usually communicate? *Check all that apply*
☐ Cries when he/she wants something ☐ Points or gestures when he/she wants something
☐ Makes sounds or babbles to try to communicate his/her needs
☐ Uses single words to communicate ☐ Combines two to three words to communicate
☐ Combines 3 or more words to communicate ☐ Uses long sentences to communicate
☐ Other:

How well do family members understand your child's speech?
☐ All the time ☐ Some of the time ☐ It is very difficult for us to understand him/her ☐ Other

How well do people outside of your family understand your child's speech?
☐ All the time ☐ Some of the time ☐ It is very difficult for us to understand him/her ☐ Other

How well do you feel your child understands what is said to him/her?
☐ All the time ☐ Some of the time ☐ It is very difficult for us to understand him/her ☐ Other

Does your child understand commonly used spoke words (i.e. hello, ball, bye)?	☐ Yes ☐ No
Does your child respond to his/her name?	☐ Yes ☐ No
Does your child focus on and name pictures in books?	☐ Yes ☐ No
Can your child point to pictures in books upon request?	☐ Yes ☐ No
Does your child answer simple "who", "what", "where", and "why" questions?	☐ Yes ☐ No
Do you feel your child has difficult hearing? If yes, please explain.	☐ Yes ☐ No
Has your child previously had hearing/screening evaluation? If yes, when and what were the results.	☐ Yes ☐ No

Do you feel your child: ☐ Responds to all sounds ☐ Responds to loud sounds ☐ Inconsistently responds to sounds
☐ Other:

FEEDING/EATING

Has your child had or does he/she current have any of the following feeding difficulties: ☐ Problems with sucking ☐ Swallowing ☐ Excessive drooling ☐ Chewing ☐ Picky Eater Please explain difficulties.			
Has your child ever had a Modified Barium Swallow Study? ☐ Yes ☐ No If yes, when was the last study done and what were the results?			
Does your child:			
Gag often on certain foods	☐ Yes ☐ No	Avoid certain textures/types/colors of food	☐ Yes ☐ No
Have difficulty chewing or swallowing food in a timely manner	☐ Yes ☐ No	Cough frequently on food or drink	☐ Yes ☐ No
Eat age-appropriate foods	☐ Yes ☐ No	Independently use all age-appropriate utensils (i.e. spoon, cup, straw)	☐ Yes ☐ No
Measure appropriate weight and height for his/her age	☐ Yes ☐ No If no, please explain.		
Have limitations on what he/she will eat	☐ Yes ☐ No If yes, please explain what your child will or will not eat. What would you like for your child to be able to eat?		