

Patient Name: _____ MRN: _____

Patient D.O.B.: _____ Date: _____

DEVELOPMENTAL PEDIATRIC INTAKE FORM

PATIENT INFORMATION

Parent / Guardian Name: _____ Relationship to Patient: _____

Pediatrician: _____ Referring MD: _____

Birth History

Date of Birth: _____ Age: _____ Type of Delivery: Vaginal Caesarean

Complications? Yes No

If yes, please explain _____

Premature Birth? Yes No

If yes, please explain _____

NICU? Yes No

If yes, please explain _____

MEDICAL HISTORY

Primary Medical Condition Requiring Rehabilitation _____ When did the problem begin _____ / _____

Briefly describe the reason for your visit

Are you/your child under the care of another Physical / Occupational / Speech Therapist for this condition? Yes No

Please list any significant medical / surgical history

Please list any hospitalizations

Have you/your child received Physical / Occupational / Speech Therapy

<input type="checkbox"/> for this condition in the past (if yes, explain below)	<input type="checkbox"/> for a previous condition (if yes, explain below)

Have you/your child seen a specialist (physician, psychologist, special education teacher, etc.)

<input type="checkbox"/> for this condition in the past (if yes, explain below)	<input type="checkbox"/> for a previous condition (if yes, explain below)

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Please indicate approximate age of onset or date for the following:

<u>Illness / Diagnosis</u>	<u>~ Age of Onset / Date</u>	<u>Illness / Diagnosis</u>	<u>~ Age of Onset / Date</u>
Allergies		Feeding Tube	
Apraxia of Speech		German Measles	
Asthma		Headaches	
ADHD		Hearing Loss	
Autism		High Fever	
Cerebral Palsy		Influenza	
Chicken Pox		Mastoiditis	
Cleft Palate / Lip		Measles	
Colds		Meningitis	
Convulsions		Mumps	
Croup		Pneumonia	
Dizziness		PE Tubes	
Down Syndrome		Reflux	
Draining Ear		Sinusitis	
Dyslexia		Stuttering	
Ear Infections		Tinnitus	
Encephalitis		Tonsillitis	
Epilepsy / Seizures		Vision Problems	

Other(s): _____

Genetic Abnormalities: _____

Learning Disabilities: _____

Is there a history of speech, language or hearing impairments in your family? (if yes, describe below) Yes No

Does your child use any of the following devices? If yes, please note device type and wearing schedule below

<input type="checkbox"/> Orthotics	
<input type="checkbox"/> Braces	
<input type="checkbox"/> Splints	
<input type="checkbox"/> Augmentative and Alternative Communication Devices	

MEDICATION INFORMATION

Please list ALL medication, vitamins, herbals and dietary supplements you are currently taking

MEDICATION (prescription, over-the-counter, vitamins, herbals, dietary supplements)	DOSAGE	FREQUENCY (times per day)	ROUTE (oral, injection, transdermal, inhale)	REASON FOR MEDICATION

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DEVELOPMENTAL PEDIATRIC INTAKE FORM

PAIN

Do you/your child have persistent or frequent pain? (If yes, complete below) Yes No

Location on body _____

Pain at WORST

Circle One

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

NO PAIN
WORST PAIN

0 NO HURT 2 HURTS LITTLE BIT 4 HURTS LITTLE MORE 6 HURTS EVEN MORE 8 HURTS WHOLE LOT 10 HURTS WORST

Pain at BEST

Circle One

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

NO PAIN
WORST PAIN

0 NO HURT 2 HURTS LITTLE BIT 4 HURTS LITTLE MORE 6 HURTS EVEN MORE 8 HURTS WHOLE LOT 10 HURTS WORST

Pain on AVERAGE

Circle One

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

NO PAIN
WORST PAIN

0 NO HURT 2 HURTS LITTLE BIT 4 HURTS LITTLE MORE 6 HURTS EVEN MORE 8 HURTS WHOLE LOT 10 HURTS WORST

Does pain awake you/your child at night? Yes No

Does pain affect your/your child's daily activities? (if yes, complete below) Yes No

Please circle all symptoms that apply

Aching Burning Numbness Tingling Throbbing Spasms Tightness Dull Pain Sharp Pain

Other: _____

Provider (print name): _____

Date: _____

Signature / Credentials: _____

Time: _____ AM / PM

DEVELOPMENTAL PEDIATRIC INTAKE FORM

SPECIAL TEST

Test Performed	Date	Result
X-Ray		
CAT Scan		
MRI		
Bone Scan		
Video Fluoroscopic Swallow Study (VFSS)		
Fiberoptic Endoscopic Evaluation of Swallowing (FEES)		
Other:		

ALLERGIES

Please indicate your allergies and allergic reactions if applicable

Allergic to	Reaction
<input type="checkbox"/> Tape	
<input type="checkbox"/> Latex	
<input type="checkbox"/> Food (specify)	
<input type="checkbox"/> Other:	

SOCIAL HISTORY

Home Status

Child lives with Both Parents Mother Grandparents
 Father Other: _____

What is the primary language spoken at home? _____

If multilingual, please note additional languages: _____

Are there steps to enter your/your child's building / home or within the home? (if yes, complete below) Yes No

Do you/your child live with siblings and/or other children? (if yes, complete below) Yes No

Number of steps to **enter** _____ Number of steps **within** _____

List your three major **FUNCTIONAL** difficulties / problems
 (e.g. self-care, household chores, changing positions, shopping, transportation, walking, communicates wants & needs)

1. _____
2. _____
3. _____

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List your/your child's three major **SYMPTOM** complaints

1. _____
2. _____
3. _____

List your/your child's **SPECIFIC GOALS** for rehabilitation

1. _____
2. _____
3. _____

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Time: _____ AM / PM

DEVELOPMENTAL PEDIATRIC INTAKE FORM

PARENT / GUARDIAN TO COMPLETE FOR MINOR

DEVELOPMENTAL HISTORY

<u>Milestone</u>	<u>Age Achieved</u>
Rolling	
Sitting	
Crawling (hands & knees)	
Walking	
Use of single words (e.g., no, mom, dad, doggy, etc.)	
Talking	
Use simple questions (e.g., where's doggy?, etc.)	
Engage in conversation	
Self-feed	
Eating puree	
Eating solid foods	
Self-dress	
Use of toilet	

Does your child exhibit any undesirable behavior(s)? (if yes, complete below) Yes No

Please note behavior trigger(s), and method(s) used to regulate / modulate / calm child's behavior

Behavior	Trigger	Intervention

Does your child exhibit frustration when he/she is not understood? (if yes, describe below) Yes No

Does your child experience difficulty with gross motor (large muscle coordination) activities? (e.g., walking, running, kicking, jumping, catching) Yes No

Does your child experience difficulty with fine motor (small muscle coordination) activities? (e.g., pinching, buttoning, writing, eating) Yes No

Has your child received a hearing screening / evaluation by an audiologist or other professional? (if yes, explain below) Yes No

Has your child received a vision screening / evaluation by a developmental optometrist or other professional? (if yes, explain below) Yes No

Has your child received Vision Therapy? (if yes, describe results below) Yes No

Does your child have a history of feeding problems? (e.g. sucking, drooling, swallowing, chewing, etc.) Yes No

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DEVELOPMENTAL PEDIATRIC INTAKE FORM

Was your child breast fed (if yes, what age was child weaned) _____ Yes No

Was your child bottle fed? (if yes, complete below) Yes No

Beginning Age _____ To Present

Weaned Age _____

Is your child on a special diet, e.g. gluten-free, casein-free, etc.? (if yes, describe below) Yes No

Does your child eat liquid? Yes No

Does your child eat solid foods? (if yes, check all that applies below) Yes No

Puree (apple sauce, stage baby food) Crunchy Solid (crackers, chips)

Soft Solid (banana, bread)

Is your child nonverbal?
(if yes, describe how your child communicates with others / type of communication device used) Yes No

Please circle method(s) of communication your child displays

Gestures

Single Words

Short Phrases

Sentences

Sign Language

Augmentative Communication Device

Other: _____

Please indicate your child's response to sound

Responds to all sounds Does not respond to sounds

Responds inconsistently to sounds Other: _____

Please describe how your child participates in the following activities

Dressing	Feeding	Bathing	Sleeping

Does your child participate in physical activities? (if yes, describe; e.g. exercise, sports) Yes No

Does your child have opportunities to interact / play with peers? (if yes, describe) Yes No

Please describe activities your child likes / dislikes

Likes	Dislikes

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School Information

Is your child currently attending school? (if yes, complete below) Yes No

School: _____ Grade: _____

How is your child performing academically or pre-academically?: _____

Does your child interact or engage with peers at school? (if no, explain below) Yes No

Does your child receive special services at school, e.g., 504 plan? (if yes, specify below) Yes No

Is your child enrolled in Special Education services? (if yes, complete below) Yes No

Has an Individualized Education Plan (IEP) been developed? (if yes, complete below) Yes No

List the primary IEP goals: _____

Please note additional comments that may facilitate therapist interaction with your child during treatment:

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Time: _____ AM / PM