

Patient Name:	MRN:
Patient D.O.B.:	Date:

DEVELOPMENTAL PEDIATRIC INTAKE FORM

Parent / Guardian Name:	Relationship to Patient:				
Pediatrician:	Referring MD:				
Birth History					
Date of Birth: Age:	Type of Delivery: Vaginal		Caesa	rean	
Complications?			Yes		No
f yes, please explain					
Premature Birth?			Yes		No
f yes, please explain					
NICU?			Yes		No
f yes, please explain					
MEDICAL HISTORY					
Primary Medical Condition Requiring Rehabilitation	When did the pr	roblem be	egin	/	,
Briefly describe the reason for your visit					
	al / Occupational / Speech Therapist for this condition?		Yes		
	al / Occupational / Speech Therapist for this condition?				
Please list any significant medical / surgical history					
Please list any significant medical / surgical history					
Please list any significant medical / surgical history					No
Please list any significant medical / surgical history Please list any hospitalizations					
Please list any significant medical / surgical history Please list any hospitalizations	I / Speech Therapy				
Please list any significant medical / surgical history Please list any hospitalizations Have you/your child received Physical / Occupational	I / Speech Therapy				
Please list any significant medical / surgical history Please list any hospitalizations Have you/your child received Physical / Occupational	I / Speech Therapy				
Please list any significant medical / surgical history Please list any hospitalizations Have you/your child received Physical / Occupational for this condition in the past (if yes, explain below)	I / Speech Therapy)				
Please list any significant medical / surgical history Please list any hospitalizations Have you/your child received Physical / Occupational for this condition in the past (if yes, explain below)	I / Speech Therapy)	plain belov	w)		
Please list any significant medical / surgical history Please list any hospitalizations Have you/your child received Physical / Occupational for this condition in the past (if yes, explain below) Have you/your child seen a specialist (physician, psyc	I / Speech Therapy)	plain belov	w)		
Please list any significant medical / surgical history Please list any hospitalizations Have you/your child received Physical / Occupational for this condition in the past (if yes, explain below) Have you/your child seen a specialist (physician, psyc	I / Speech Therapy)	plain belov	w)		
Please list any significant medical / surgical history Please list any hospitalizations Have you/your child received Physical / Occupational for this condition in the past (if yes, explain below) Have you/your child seen a specialist (physician, psyc	I / Speech Therapy)	plain belov	w)		



Signature / Credentials:

Patient Name:	 MRN:	
Patient D.O.B.:	Date:	

Time: _____ AM / PM

Braces Splints	Illness / Diagnosis	~ Age of Onset / Date		<u>Illness / Di</u>	iagnosis	~ Age of Onset / Date
Apravia of Speech Asthma Headaches Asthma Headres ASTHMA ADHD Hearing Loss Autism Cerebral Palsy Influenza Chicken Pox Mastoiditis Cleft Palate / Lip Colds Convulsions Mumps Croup Pneumonia Dizziness PET Ubes Down Syndrome Reflux Draining Ear Draining Ear Sinusitis Dyslexia Ear Infections Encephalitis Epilepsy / Seizures Other(s): enetic Abnormalities: Learning Disabilities: Learning Disabilities: there a history of speech, language or hearing impairments in your family? (if yes, describe below) Orthotics Braces Splints Augmentative and Alternative Communication Devices MEDICATION (prescription, over-the-counter, vitamins, herbals and dietary supplements you are currently taking MEDICATION (prescription, over-the-counter, vitamins, herbals and dietary supplements you are currently taking MEDICATION (prescription, over-the-counter, vitamins, herbals and dietary supplements you are currently taking	Allergies			Feeding Tu	ıbe	
ADHD Autism Cerebral Palsy Chicken Pox Chi						
Autism Cerebral Palsy Cerebral Palsy Cleft Palate / Lip Colds Cleft Palate / Lip Colds Measles Convulsions Croup Pneumonia Dizziness PE Tubes Down Syndrome Down Syndrome Draining Ear Down Syndrome Draining Ear Sinustits Dyslexia Ear Infections Ear Infections Ear Infections Encephalitis Tinnitus Encephalitis Epilepsy / Seizures Other(s): enetic Abnormalities: there a history of speech, language or hearing impairments in your family? (if yes, describe below) Orthotics Braces Splints Augmentative and Alternative Communication Devices MEDICATION (prescription, over-the-counter, vitamins, herbals and dietary supplements you are currently taking MEDICATION (prescription, over-the-counter, vitamins, herbals and dietary supplements you are currently taking MEDICATION (prescription, over-the-counter, vitamins, herbals and dietary supplements you are currently taking MEDICATION (prescription, over-the-counter, vitamins, herbals and dietary supplements you are currently taking MEDICATION (prescription, over-the-counter, vitamins, herbals and dietary supplements you are currently taking				Headaches	3	
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Signature / Credentials:

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Does pain a	wake yo	u/your child at	night?								Yes		No
Does pain at	ffect you	r/your child's	daily act	ivities? (if y	es, complete	below)					Yes		No

LITTLE B Does pain awake you/your child at night? Does pain affect your/your child's daily activities Please circle all symptoms that apply Aching Burning Numbness Tingling Throbbing Spasms Tightness **Dull Pain** Sharp Pain Other: Provider (print name): Date:

Time: _____ AM / PM



Patient Name:	MRN:	
Patient D.O.B.:	Date:	
Taticit D.O.D	Date.	

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 applical	ble				
Allergic to	Reactio	on			
Таре					
Latex					
☐ Food (specify)					
☐ Other:					
SOCIAL HISTORY					
Home Status					
Child lives with Both Parents		Mother □ Grandp	arents \square		
		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 ho	me? (if yes, complete below)		Yes	No
Do you/your child live with siblings and/or other children? (if	yes, complete b	elow)		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, trans	sportation, walk	ing, communicates wants & needs	5)		
1					
2					
3.					
Provider (print name):		Date:			

Signature / Credentials:



Patient Name:	 MRN:	
Patient D.O.B.:	 Date:	

ture / Credentials:	Time:	AM / PM	
rovider (print name):	Date:		
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your/your child's SPECIFIC GOALS for rehabilitation			
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Patient Name:	MRN:
Patient D.O.B.:	Date:

DEVELOPMENTAL PEDIATRIC INTAKE FORM

PARENT / GUARDIAN TO COMPLETE FOR MINOR

<u>Milestone</u>		Age A	chieve	<u>d</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	Interv	ention		
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 profession if yes, explain below)	nal?	Yes		No
		Yes		No
las your child received Vision Therapy? (if yes, describe results below)				
las your child received Vision Therapy? (if yes, describe results below) Does your child have a history of feeding problems? (e.g. sucking, drooling, swallowing, chewing, etc.)		Yes		No
		Yes		No
		Yes		No



Montefiore	Patient Name	Patient Name:			MRN:				
	Patient D.O.E	3.:		Date:					
			DEVELOPMENTA	L PEDIATI	RIC IN	ΓΑΚΕ	FORM		
Was your child breast fed (if yes, what age was	s child weaned)				Yes		No		
Was your child bottle fed? (if yes, complete be	elow)				Yes		No		
Beginning Age			To Present						
Weaned Age									
Is your child on a special diet, e.g. gluten-fre	e, casein-free, etc.? (if yes,	. descri	pe 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, chi	ps)					
☐ Soft Solid (banana, bread)									
Is your child nonverbal? (if yes, describe how your child communicates with	th others / type of communica	ation d	evice used)		Yes		No		
Please circle method(s) of communication ye	our child displays								
Gestures	Single Words			Short P	hrases				
Sentences	Sign Language		Augmo	entative Com	municat	ion De	vice		
Other:									
Please indicate your child's response to sour	nd								
☐ Responds to all sounds			Does not respond to sound	5					
☐ Responds inconsistently to sounds			Other:						
Please describe how your child participates	in the following activities								
Dressing	Feeding		Bathing		Sleepi	ng			
Does your child participate in physical activity	ties? (if yes, describe; e.g. ex	ercise,	sports)		Yes		No		
Does your child have opportunities to intera	ct / play with peers? (if yes	s, descr	ibe)		Yes		No		
Please describe activities your child likes / di	slikes								
Likes			Dis	likes					
Provider (print name):			Date:						
gnature / Credentials:			Time: A	M / PM					



Patient Name:	MRN:	
Patient D.O.B.:	Date:	

	DEVELOPM	ENTAL PED	IATE	RIC INT	ГАКЕ	FOR
<u>School Information</u>						
Is your child currently attending school? (if yes, complete below	N)			Yes		No
School:		Grade:				
How is your child performing academically or pre-academic						
Does your child interact or engage with peers at school? (if n	o, explain below)			Yes		No
Does your child receive special services at school, e.g., 504 p	lan? (if yes, specify below)			Yes		No
ls your child enrolled in Special Education services? (if yes, co	mplete below)			Yes		No
Has an Individualized Education Plan (IEP) been developed? List the primary IEP goals:				Yes		No
Please note additional comments that may facilitate therapi	st interaction with your child during t	reatment:				
Provider (print name):	Date:					
nature / Credentials:	Time:	AM / P	М			