Montefiore

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

☐ for this condition in the past (if yes, explain below)	☐ for a previous condition (if yes, explain below)

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

☐ for this condition in the past (if yes, explain below)	☐ for a previous condition (if yes, explain below)

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DEVELOPMENTAL PEDIATRIC INTAKE FORM

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

Illness / Diagnosis	~ Age of Onset / Date	Illness / Diagnosis	~ Age of Onset / Date
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

Device	
☐ Orthotics	
☐ Braces	
☐ Splints	
☐ 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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Montefiore

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Patient D.O.B.: ______________________ Date: ________________

DEVELOPMENTAL PEDIATRIC INTAKE FORM

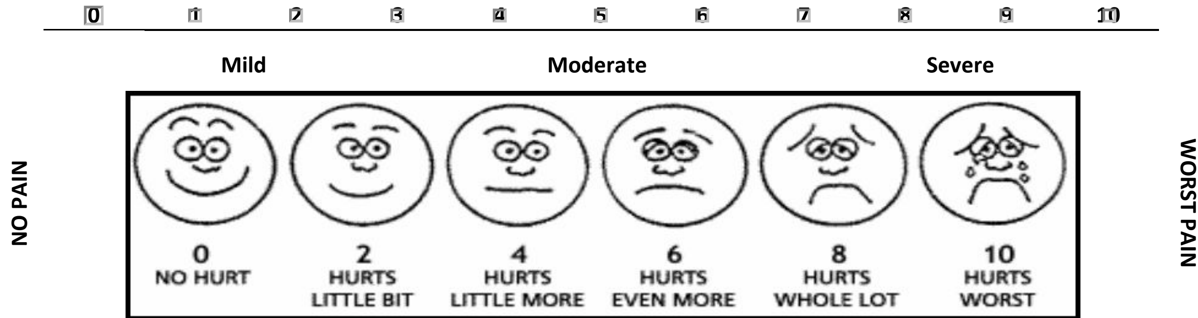
PAIN

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

Location on body ____

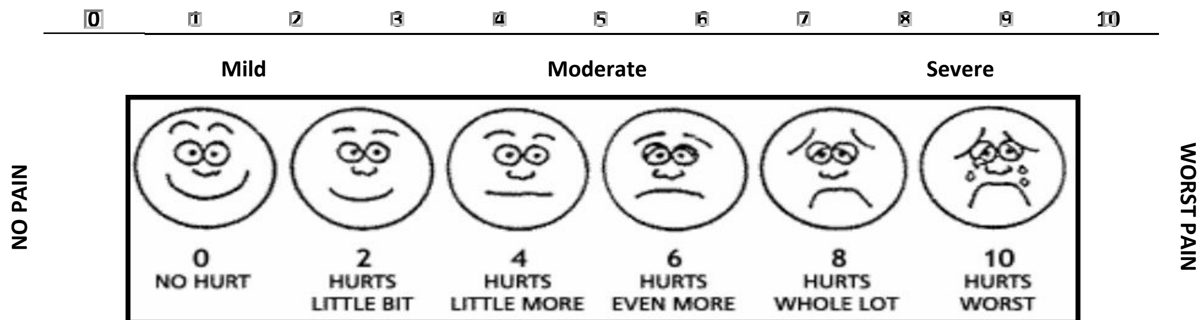
Pain at WORST

Circle One



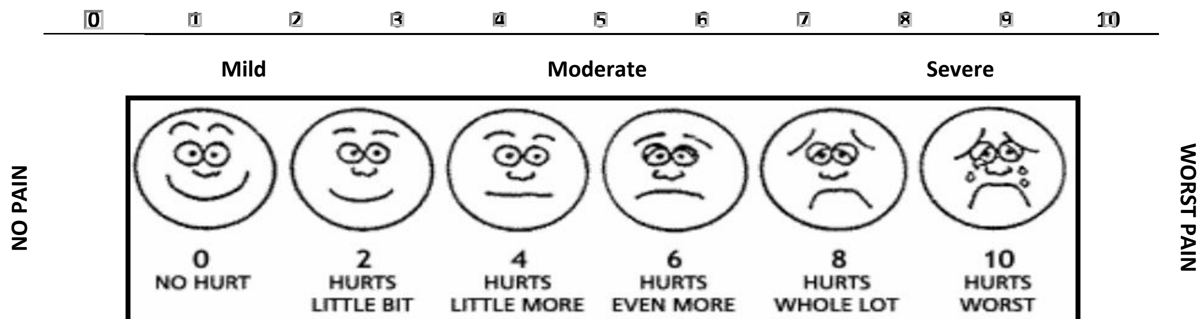
Pain at BEST

Circle One



Pain on AVERAGE

Circle One



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
☐ Tape	
☐ Latex	
☐ Food (specify)	
☐ 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. ____________

Provider (print name): ____________ Date: ____________

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Montefiore

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DEVELOPMENTAL PEDIATRIC INTAKE FORM

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

1. ______________________________
2. ______________________________
3. ______________________________

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

1. ______________________________
2. ______________________________
3. ______________________________

Provider (print name): ______________________ Date: ________

Signature / Credentials: ______________________ Time: ________ AM / PM

Montefiore

Patient Name: ____________________ MRN: ______________

Patient D.O.B.: ____________________ Date: ______________

DEVELOPMENTAL PEDIATRIC INTAKE FORM

PARENT / GUARDIAN TO COMPLETE FOR MINOR

DEVELOPMENTAL HISTORY

Milestone	Age Achieved
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

Provider (print name): ______________________ Date: ________

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Montefiore

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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

Provider (print name): ________________________ Date: ________

Signature / Credentials: ________________________ Time: ________ AM / PM

Montefiore

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DEVELOPMENTAL PEDIATRIC INTAKE FORM

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:

Provider (print name): ______________________________ Date: __________

Signature / Credentials: ______________________________ Time: __________ AM / PM