Montefiore

Patient Name: _____ MRN: _____

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

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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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

☐ 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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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

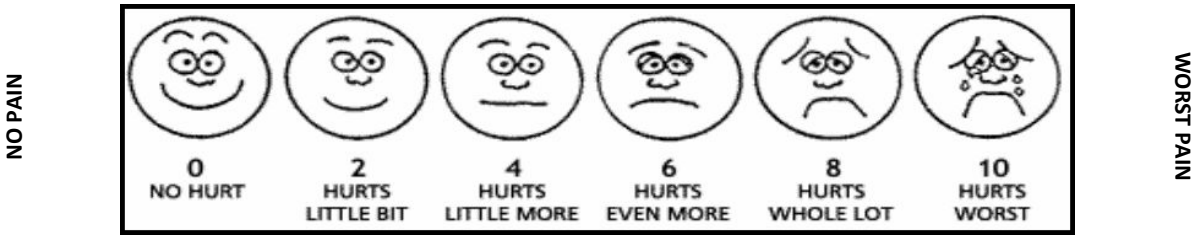
0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Pain at BEST
Circle One

0 1 2 3 4 5 6 7 8 9 10

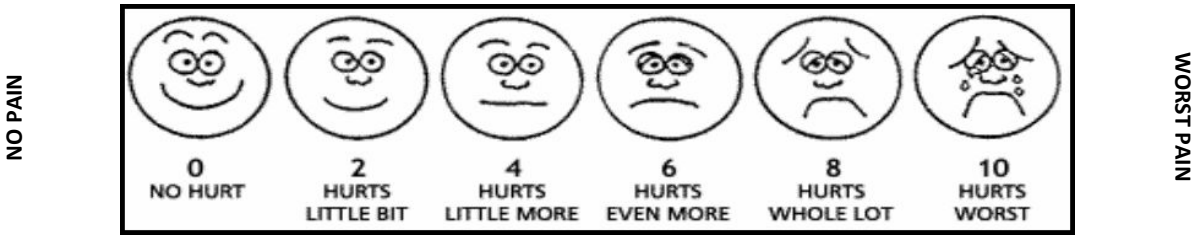
Mild Moderate Severe



Pain on AVERAGE
Circle One

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe



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: _____

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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. _____

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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. _____

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