Speech and Occupational Therapy
4700 S Mill Ave #3, Tempe, AZ 85282 | 480-508-7566

Pediatric Intake Form

Today's Date _______________

Child's Name _________________________________ Date of Birth ____________ Gender _________

Address ____

Parent/Guardian__________________________ Phone # _______________Email____________________

Primary Insurance:
Name of Insurance Company____
Policyholder's Name ____
Policyholder's Date of Birth____
Policy Number _______________________________ Group Number ______________________________

Secondary Insurance:
Name of Insurance Company____
Policyholder's Name ____
Policyholder's Date of Birth____
Policy Number _______________________________ Group Number ______________________________

Referral and Present Concerns:
Who referred your child for therapy?____
Describe your present concern(s) ____
____
Does your child have any current diagnoses? _____ Yes _____ No
If yes, what? ____
Who made the diagnosis? ___________________________________
Previous Evaluations:____
____
Therapy to date:____
What are your goals for this evaluation and for your child's therapy?_________________________________
____

Where did you hear about us: ____

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Prenatal History
During Pregnancy, did the mother:

Have health problems?	yes	no
Use any drugs/medications?	yes	no
Incur accident or injury?	yes	no
Smoke?	yes	no
Drink alcohol	yes	no
Have prenatal care?	yes	no

Birth History:
Mother's age at birth ______ Hours of Labor ______ Length of hospital stay______
Birth weight ___ lbs. ____ozs Length ________________ Adopted _______________

Was birth premature?	yes	no	If yes, how many weeks?___
Was baby placed in an incubator?	yes	no	
Was anesthetic used during delivery?	yes	no	
Difficulties breathing after birth?	yes	no	
Did the delivery require forceps?	yes	no	
Was the child discolored?	yes	no	
Any birth injuries/defects?	yes	no	
Seizures?	yes	no	
Any difficulties in the first two weeks of life?	yes	no	
Did your child require special formula?	yes	no	
Does your child have a history of colic?	yes	no	
Would you say your child is in good health?	yes	no	

If you selected no, please explain:

____

____

Infant Development
At what age did you child:

Sit alone:	Mos_______	Crawl:	Mos_______
Stand alone:	Mos_______	Walk alone:	Mos_______
Speak first words:	Mos_______	Speak first sentences:	Mos_______
Toilet train:	Mos_______	Feed self:	Mos_______
Dress self:	Mos_______		

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Medical History

Has your child ever had:

Allergies (seasonal/food)	yes	no
Earaches or frequent ear infections	yes	no
Asthma	yes	no
Prolonged fever	yes	no
Head injury	yes	no
Seizures or convulsions	yes	no
Extended hospitalizations	yes	no
Operations or surgeries	yes	no
Sustained medication	yes	no

If you selected yes, please explain:
____
____

Does your child have any current health problems that interfere with daily functional skills? If yes, please describe: ____

Has your child been/is your child under treatment of a physician, counselor, and/or psychologist?
If yes, describe: ____
____

Has your child had any operations?____

Been knocked out unconscious? ____

Please list allergies to food, medicine, or other: ____

Please list current medications (including over the counter, homeopathic, and herbal/ vitamin supplements)
____
____

Family History:

Mother's Name:______________________________ Occupation:_________________________

History of Speech, Language, or Learning problems? YES_________NO__________

If YES, explain____

Father's Name:______________________________ Occupation:_________________________

History of Speech, Language, or Learning problems? YES_________NO__________

If YES, explain____

Lives with: parents/caregivers (name/s) ____

Siblings (names, ages) ____

Language(s) spoken around the child:____

Is there family history (parents, siblings, aunts, uncles, cousins, grandparents) of any of the following:

Hearing Loss_________ Alcoholism_________ Learning Disability________ Seizure Disorder________

Reading Difficulty_______ Mental Illness________ Speech Difficulty______ Drug Abuse____________

Eating Disorder____________

If yes response given, please describe:____
____

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Academic History:
Current School and Grade ____
What are your child's *most* successful subjects? ______________________________
What are your child's *least* successful subjects? ______________________________
Does your child perform ___ at grade level ___ above grade level ___ below grade level
Please describe: ____
Does your child currently have an Individualized Education Plan (IEP) and/or receive special services?
___ Yes ___ No
Please Explain: ____
____

Hearing (please check box)
Date of last hearing test: ______________

Normal hearing/no concern   not tested

Hearing screened   BAER test   full audiological evaluation   Hearing impaired   hearing aid/s

Chronic upper respiratory infections (detail) ______________________________

History of recurrent ear infections (detail) _______________________________

History of "tubes" _____ Past _____ Present (details)_________________________

Any concerns with hearing? _____ Yes ____ No   If yes, please explain:
____

Vision (please check box)
Date of last vision test: _______________

Normal Vision/no concern   not tested

Vision problem   Glasses/Contacts   Full vision evaluation   Vision Therapy Details:
____
Any concerns with vision? _____ Yes ____ No   If yes, please explain:
____

Behavioral (inattention, physical aggression, blaming others, anxiety, depression, etc.)**:**
Are there any behavioral concerns we should know about? Please explain:
____
____
____

Social (fights with others, avoids eye contact, seems withdrawn, has poor relationships with peers, etc.)**:**
Are there any social concerns we should know about? Please explain:
____
____
____

Emotional (poor self-esteem, bites nails, sucks thumb, frequent crying, can't express feelings, etc.)**:**
Are there any emotional concerns we should know about? Please explain:
____
____
____

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Personality (acts immature, disobedient, easily frustrated, poor memory, wants to be perfect, etc.)**:**
Are there any personality concerns we should know about? Please explain:

____
____
____

Do you see any of the following in your child:

dislikes messy hands   difficulty with hygiene (toothbrush/nail cut/haircut)

difficulty sitting still   difficulty sleeping   difficulty with certain textures (clothing or foods)

difficulty calming when upset   child uses too much pressure frequently (ex: breaks crayons)

frequently falls or trips

If you marked any of the above, an occupational therapy consultation is highly recommended.

Feeding/Swallowing (please check box)

Feeds/drinks independently at age-appropriate level

nursing   uses bottle   sippy cup   regular cup   utensils

Problems with textures (list textures, i.e., crunchy, pudding-like) ______________________________

Previous swallow studies (list date, risk of aspiration): ______________________________

History of intubation (date, details) ______________________________

History of g-tube (date, details) ______________________________

Problems with reflux (detail)______________________________

Please list diet restrictions: ______________________________

Communication Status (please check box)   Communicates at age-appropriate level

Points/gestures   signs   verbal (words)   uses PECS   uses augmentative communication device
Details: ______________________________

Availability:

Attends school M T W Th F (times) ______________________________

Other therapy appointments (indicate time/day for each) PT ____________ OT ____________
ST ____________ Other ____________

Best day(s) and time(s) for therapy ______________________________

THANK YOU for taking the time to help us better understand your child; completing this form empowers us to develop individualized therapy plans specific to your child's needs. Please update us if there are changes in your child's condition and/or medications.