Playworks-Pediatric Therapy Services
12880 Hillcrest Rd. Suite 102
Dallas, TX 75230
972.387.1100 / fax 972.692.7332

INTAKE INFORMATION FORM

Today's Date: _____

1. Client Information:

Child's Legal Name: _____

Child Goes By:_____

Birth Date: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

2. Parents/Guardian:

Mother: _____ Birth Date: _____ Age: _____

Occupation: _____ Employer: _____

Work Phone: _____ **Cell Phone:*** _____

E-Mail:* _____ Best # to reach you: _____

Father: _____ Birth Date: _____ Age: _____

Occupation: _____ Employer: _____

Work Phone: _____ **Cell Phone:*** _____

E-Mail:* _____ Best # to reach you: _____

Please Indicate: Single _____ Married _____ Separated _____ Divorced _____

Who has legal guardianship of the child? _____

Responsible Party: _____ Driver's License #: _____

Billing Address if different from home: _____

City: _____ State: _____ Zip Code: _____

3. Referral Information:

Who referred you? _____

Reason for Referral? _____

Profession/Relationship: _____

Does your child have a diagnosis? Yes_____ No_____ Please describe: _____

Who gave the diagnosis? _____

4. Child's Primary Physician:

Physician's Name: _____

(This physician will be writing orders for therapy)

Physician's Address:_____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

5. Primary Concerns:

What are your primary concerns about your child?_____

_____

_____

_____

When did you first become concerned? _____

_____

_____

Have the concerns changed in the past few months? _____

_____

_____

What are the hardest times of day/most difficult activities for your child? _____

_____

_____

What are your goals for your child? _____

_____

_____

6. Birth History:

Where was the child born (city, state and hospital)? _____

Mom's health during pregnancy: Good_____ Fair_____ Poor_____

Did the Mother:	Yes or No	Please Explain
Have any infections/illnesses?		
Have any unusual stress during pregnancy?		
Have any labor or delivery complications?		
Take any medications during pregnancy?		
Infertility Issues?		

Child's Birth:

Delivery: Vaginal _____ C-Section _____ Planned or Emergency? _____

Birth weight: _____lbs. _____oz.

Full Term _____ Premature _____ If premature, how early? _____

Was he/she small for gestational age? Yes _____ No _____

Was labor induced? Yes _____ No _____

If premature, see additional chart.

Delivery:

Was or Did Child:	Yes or No	Please Explain
Breech?		
Need oxygen?		
Need transfusions?		
Failure to progress?		

Please comment on any difficulties that were present with delivery: _____

_____

Please Indicate	Please Explain
Is the cause known?	
Breathing difficulties?	
Feeding difficulties?	
Significant events that occurred during hospitalization? (tests, surgeries, illness, etc.)	
Is the child the product of a multiple birth?	
If so, how are the other siblings doing?	

Did your child spend time in the NICU? Yes _____ No _____

Length of time spent in NICU or hospital: _____

Name of hospital: _____

Need for readmission? Please explain: _____

_____

7. Medical History:

Child's general health at present is: Good _____ Fair _____ Poor _____

Is your child immunized? Yes _____ No _____

If no, please explain: _____

Are immunizations up to date? Yes _____ No _____

If no, please explain: _____

Has your child had a vision test? Yes _____ No _____

If yes, when? _____ By whom? _____

Results: _____

Has your child had a hearing test? Yes _____ No _____

If yes, when? _____ By whom? _____

Results: _____

Please indicate if any of the following apply to your child's medical history:	Date	Please Explain
Serious Illness?		
Injuries?		
Congenital Abnormalities?		

Surgery?		
Ear Infections/Tubes?		
Seizures?		
X-rays, CT Scans, MRI, or EEG?		Results:
Genetic Testing?		Results:
Other (disease, chronic illness, etc.)		

Allergies:

Allergies to Medications? Yes _____ No _____

Please List: _____

Allergies to Food? Yes _____ No _____

Please List: _____

Special Diet? Yes _____ No _____

Please List: _____

Allergies to Environmental/Respiratory Agents? Yes _____ No _____

Pollen _____ Dust _____ Food _____ Animal _____

Other: _____

List any medications your child is currently taking:

Medication	Dosage	Purpose

Are there any medical precautions the therapist should be aware of when working with your child?

Please list and describe:

_____

_____

_____

Does your child have any assistive devices (glasses, braces, wheelchair, hearing, communication devices, etc.)?

_____

_____

Has your child received any other evaluations or treatment by any other professionals (OT, ST, PT, Developmental Pediatrician, etc.)? Yes _____ No _____

Evaluations/Services	Professional's Name	Therapy Dates (beginning and end)

Any recommendations, plan of action, results from testing:

_____

_____

_____

8. Family History:

Was this child adopted? _____ At what age? _____ From where? _____

Names of Siblings	Age	Sex	Grade Level

Do these siblings live with the child? _____ Are any adopted? _____

If adopted, please indicate whom: _____

Is there a history of learning difficulties, developmental delays, attention issues, mental health disorders and/or genetic disorders in your family?

Name	Relationship	Describe Problem

Who does your child remind you of and how? _____

_____

9. Developmental History and Current Functional Levels:

Was your child as an infant…? (check all that apply)

_____	Fussy, irritable	_____	Floppy when held
_____	Non-demanding	_____	Tense/stiff when held
_____	Irregular sleep patterns	_____	Liked being held
_____	Overactive, never still unless sleeping	_____	Difficulty or disliked being positioned on stomach

Did your child suffer from reflux? Yes _____ No _____

Describe (need for medication or special formula, etc.) _____

_____

_____

Developmental Milestones:

*Give **approximate ages** if remembered, or comment on anything unusual for the following:*

_____	Roll over	_____	Walk
_____	Sit alone	_____	Chew solid food
_____	Crawl	_____	Drink from a cup
_____	First words	_____	Combined words

Was crawling phase brief? Yes _____ No _____ Absent _____

Did your child use a walker (rolling plastic seat)? Yes _____ No _____

If yes, how often? _____

Has your child demonstrated a hand preference? Yes _____ No _____

If yes, which one? _____

Check which describes your child at present:

_____	Tires easily	_____	Resistant to changes/stubborn
_____	Too impulsive	_____	Fights frequently/aggressive
_____	Over reacts	_____	Clumsy / falls often
_____	Poor attention span	_____	Easily frustrated
_____	Talks constantly	_____	Cries often
_____	Restless	_____	Frequent temper tantrums
_____	Has difficulty separating from primary caretakers		

Feeding:

Do you have concerns regarding your child's feeding/eating skills? _____

_____

Do you consider your child a picky eater? _____

_____

Does your child have strong food preferences? If so, please describe: _____

_____

Does your child avoid certain textures or flavors? _____

_____

Sleep Patterns:

Do you have concerns with your child's sleep habits? Yes_____ No_____

Does your child have regular sleep patterns? Yes _____ No _____

If no, describe: _____

Does your child wake frequently during the night? Yes _____ No _____

If yes, describe: _____

Does your child tend to be an early riser, up and on the go? Yes _____ No _____

Does your child have difficult time falling asleep? Yes _____ No _____

Where does your child sleep? _____

Does your child have a routine for going to sleep? Yes _____ No _____

If yes, describe: _____

Does your child snore? Yes _____ No _____

Developmental Skills:

Can your child:	**Yes**	**No**	**Has some difficulty**
Dress self independently?			
Undress self independently?			
Manipulate fasteners independently? (ex. buttons + zippers)			
Ride a tricycle or bicycle? With or without training wheels?			
Toilet trained? Please describe (accidents, night-time trained, etc.:)_____ _____			

Has your child achieved some skills and then lost them? Yes _____ No _____

If yes, describe: _____

_____

10. School Skills:

School Name: _____

Teacher: _____ Grade: _____

Has your child changed schools frequently? (at least once a year) Yes _____ No _____

Is your child considered to have difficulty in any of the following? (check all that apply)

_____	Reading	_____	Finishing a task
_____	Math	_____	Remembering information
_____	Spelling	_____	Paying attention
_____	Handwriting	_____	Organizing work
_____	Following directions	_____	Restlessness
_____	Other: _____		

What are your child's favorite subjects in school? _____

_____

What are your child's least favorite subjects in school? _____

_____

Has your child ever been asked to leave school? Yes _____ No _____

If yes, for what reason? _____

_____

Is your child's teacher aware of your concerns? _____

_____

Please describe teacher's concerns: _____

_____

11. Sensorimotor Skills:

Does your child:	**Often**	**Sometimes**	**Rarely/Never**	**Comments**
Tend to be slow in dressing?				
Have difficulty with or takes a long time with tasks that have multiple steps?				
Bump into things frequently?				

Seem weaker than others his or her age?				
Tire easily with physical activity?				
Prefer playground to table activities?				
Appear reluctant to participate in sports and games?				
Find activities with small pieces difficult?				
Tend to move in and out of chair while eating or doing work?				
Prefer to eat with his or her hands?				
Drool?				

12. Play Skills:

What keeps your child's interest? _____

_____

How does he or she play with toys? _____

_____

What activities does your child <u>least</u> enjoy? _____

_____

13. Speech – Language Information:

What is your child's first language?

_____ English _____ Spanish _____ Hebrew _____Sign Language

_____ Voice and Sign Other: _____

Are there any other languages spoken in your home? _____

_____

Please check the concerns you may have regarding your child's hearing/speech-language development:

_____	Nonverbal	_____	Hearing Loss
_____	Not able to verbally express him/herself	_____	Pronunciation/articulation problem
_____	Voice Quality	_____	Difficulty with school work
_____	Stuttering/dysfluency	_____	Reading problem
_____	Language comprehension problem		

Other: _____

_____

How does your child usually communicate? *(Check all that apply)*

_____ Gestures _____ Sounds _____ Single Words _____ Short Phrases

_____ Sentences _____ Pointing

Other: _____

What **percentage** of your child's speech is understood by:

Parents_____ Familiar Adults _____ Strangers_____

How many words are in your child's vocabulary? (Check one)
_____ Under 25 _____ 25-75 _____ Over 75

Does your child continue to learn new words? Yes _____ No _____

Has your child ever talked better than they do now? Yes _____ No _____

If yes, when? _____

Does your child generally understand what is said to him/her? Yes _____ No _____

If no, explain: _____

Has your child's speech, communication or hearing ever had a notable change? Yes _____ No _____
If yes, explain: _____

14. Social Skills:

Does your child:	**Often**	**Sometimes**	**Rarely/Never**	**Comments**
Make friends easily?				
Tend to prefer to play alone?				
Adapt easily to change?				
Seem sensitive to criticism?				
Lack self-confidence?				
Seem hesitant to join other peer groups?				

Act younger than his/her age?				
Have trouble getting along with other children?				
Prefer the company of adults to children?				
Prefer playing with children who are 1-2 years younger?				
Seem discouraged or depressed?				

With whom does the child spend most of his/her day?_____

Names of others closely involved with the child: _____

What extra-curricular activities is your child involved in? (Gymnastics, swimming, soccer, Scouts, etc.) _____

_____

_____

Describe your child's special habits or unusual fears:_____

_____

Behavior:

Describe your child's ability to:

Concentrate / pay attention: _____

Learn: _____

Cooperate / obey: _____

Manage time (sequence daily tasks): _____

Organize:_____

Start and finish a task: _____

Transition in between tasks: _____

What motivates your child? _____

_____

What types of discipline do you use with your child? _____

_____

How does your child respond to discipline? _____

_____

***Important Information* Information in this section <u>MUST</u> be completed.**

1. List of Allergies _____

   _____

2. Will someone other than the parent bring or pick up your child to/from the clinic? If so, who?

   _____

   Relationship to child: _____ Contact information: _____

3. At times we celebrate holidays through our fine motor and language activities. Does your family have strong religious or cultural preferences?_____

   _____

4. Emergency Contact (grandparent, neighbor, relative, etc.)

Name: _____ Relationship: _____

Phone: _____ Cell: _____