Playworks-Pediatric Therapy Services
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AGES 0-3 YEARS 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 _____

10. 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? _____

_____

11. 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: _____

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

Names of others closely involved with the child: _____

***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: _____