Occupational Therapy & Speech Therapy Pediatric Intake Form

Child's Information				
Last Name			**First Name**	
Date of Birth	**Age**	**Gender**	**Ethnicity**	**Primary Language(s) Spoken**

Parent/Guardian Information
Please put a * by your preferred method of contact (phone/email)
If addresses differ, please put a * next to where the child spends most of their time

Parent/Guardian 1		Parent/Guardian 2	
Last Name	**First Name**	**Last Name**	**First Name**
Relationship to Child		**Relationship to Child**	
Primary Phone		**Primary Phone**	
Email		**Email**	
Street Address		**Street Address**	
City, State, Zip Code		**City, State, Zip Code**	

Other People in the Household Please list anyone who lives in the household and their relationship to the child	
Name	**Relationship to the child**

Referred by:		**Main Concerns:**	
Physician:		**Facility:**	
Daycare/preschool/school (if applicable):			
Name of school:		**Grade:**	
Name of Teacher:		**Does your child receive additional services in school?**	**Yes** ☐ **No** ☐
Please describe your child's strengths in school:		**Is your child having difficulty with any school subjects? If so, please explain.**	
Evaluation/Treatment History:			
Has your child had any previous evaluations or tests? If yes, please explain.			

Has your child received any previous therapy outside of school (e.g., Speech Therapy, Occupational Therapy, etc.)? If yes, please explain.
Other Information:
What are your child's favorite interests/games/activities/toys?
Please tell us anything that may help us better understand your child:

Medical/Developmental History

Birth/Health History			
Please explain any difficulties before, during, or after the birth of your child:			
Length of pregnancy:		**Birth weight:**	
Length of stay in the hospital:		**Type of delivery:**	
Please explain any current medical conditions and/or diagnoses (e.g., ADHD, autism):			
Please list any medication your child takes regularly:			

Hearing	**No**	**Yes**	**If yes, explain:**

Have you ever had concerns about your child's hearing?	☐	☐	
Does your child use any amplification or other devices to aid hearing?	☐	☐	
Did/does your child have frequent ear infections?	☐	☐	
When was your child's most recent hear screening?	ing		
What were the results of the hearing screening?			
Vision	**No**	**Yes**	**If yes, explain:**
Have you ever had concerns about your child's vision?			
Does your child currently wear corrective lenses?			

Speech and Language Development	
At approximately what age did your child begin to do the following: (Write N/A if not applicable)	**Age:**
Babble (sound combinations such as "bababa" or "gaga")	
Say first word	
Jabber in nonsense sentences that sound like adult language	
Begin to put words together (e.g., "mommy play", "want drink")	
Use complete sentences	

Is there any family history (including siblings) of speech, language, or learning difficulties? If yes, please describe.

Other Developmental Areas Please indicate if you have had in the past or currently have concerns in the following areas of development:	**Current Concern**	**Past Concern**
Motor development (e.g., crawling, sitting, walking, running)		
Self-help (e.g., dressing, toileting)		
Feeding (e.g., drooling, choking, sensitivity to textures)		
Early play (e.g., using toys appropriately)		

Please explain any concerns indicated:

Speech and Language Information

Chief Concerns

- What are your concerns about your child's communication?
- What are your expectations from this evaluation?

How does your child <u>usually</u> express him/herself?			
☐	**Actions** (e.g., crying, pulling adult's hand, pushing adult's body)	☐	**1-2 word sentences**
☐	**Sounds** (e.g., babbling)	☐	**3-4 word sentences**
☐	**Gestures** (e.g., pointing)	☐	**Complete sentences**
☐	**Other** (e.g., sign language, picture exchange, communication board or device)		
Please describe:			
How often can <u>you</u> understand what your child is saying?			
☐	All of the time	☐	Some of the time
☐	Most of the time	☐	Almost never
How often can <u>others</u> (e.g., teachers, extended family members, etc.) understand what your child is saying?			
☐	All of the time	☐	Some of the time
☐	Most of the time	☐	Almost never
Comments on speech production skills:			

Are any of the following a concern for your child?	Yes	No
Expresses frustration when trying to communicate	☐	☐
Has difficulty pronouncing certain sounds	☐	☐
Has difficulty answering questions	☐	☐
Repeat things others say/repeat long strings of speech from TV shows/videos	☐	☐
Has difficulty following directions	☐	☐
Struggles to convey a clear message when speaking, even if words are easy to understand	☐	☐
Gets stuck on or repeats words when talking	☐	☐
Has difficulty with his/her voice, vocal quality, or breathing	☐	☐
Has a hard time making friends	☐	☐
Has difficulty understanding and following social rules	☐	☐

Please explain any "yes" answers about your concerns. Please give examples if possible.

Occupational Therapy information

Behavior and Social Skills					
Are any of the following a concern for your child					
	Yes	No		Yes	No
Initiates Conversation	☐	☐	Takes turns with peers	☐	☐
Makes eye contact	☐	☐	Displays aggression	☐	☐
Has safety awareness	☐	☐	Prefers to play alone	☐	☐
Impulsive/takes risks	☐	☐	Has tantrums	☐	☐
Pays attention	☐	☐	Extremely sensitive	☐	☐
Listens well	☐	☐	Unable to self-calm	☐	☐

Plays well with others	☐	☐	Does not like crowds	☐	☐
Follow verbal directions	☐	☐	Does well with change	☐	☐
Please explain any "yes" answers about your concerns. Please give examples if possible.					

Daily Routine- Self Care		
Any of the following a concern for your child	Yes	No
Does your child have difficulty with the morning/night time routine?	☐	☐
Does your child have difficulty falling asleep?	☐	☐
Does your child wake during the night?	☐	☐
Is your child able to fasten clothing (e.g., buttons, zippers, snaps)	☐	☐
Can your child dress her/himself (e.g., pull up pants/underwear, put on shirt/socks/shoes)	☐	☐
Is your child bathroom trained	☐	☐
Is your child able to brush teeth and hair independently	☐	☐
Please explain any "yes" answers about your concerns. Please give examples if possible.		

Sensory Processing		
Are any of the following a concern for your child	Yes	No
Tolerates self-care (e.g., bathing, tooth brushing, hair brushing)	☐	☐
Appears clumsy (e.g., trips, bumps into objects/people, trouble with coordinating body parts)	☐	☐
Has a fear of using playground equipment (e.g., swinging, feet leaving the ground, heights)	☐	☐
Is constantly moving, seeks intense pressure/movement	☐	☐
Has difficulty keeping hands to him/herself	☐	☐
Avoids messy play/doesn't like when hands get dirty	☐	☐
Appears overly sensitive to certain textures, smells, noises	☐	☐
Chews on non-edible objects/puts them in his/her mouth	☐	☐
Often invades others personal space	☐	☐
Has poor body awareness (e.g., unaware if hands are dirty, being touched or bumped into)	☐	☐
Please explain any "yes" answers about your concerns. Please give examples if possible.		