Rehabilitation Department
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PEDIATRIC THERAPY CLINIC

Physical Therapy – Occupational Therapy – Speech Therapy

INTAKE & BACKGROUND QUESTIONNAIRE

Patient Information Today's Date:____________

Child's Name_______________________________________ Age_____________________

Date of Birth_____/_____/________ Gender __________________

Child's Home Address____

What are your primary concerns for having your child evaluated and treated?

____

____

____

Medical Information

Referring Physician______________________________________

Primary Care Physician___________________________________

Clinic Name____

Diagnosis_________________________________ Date of Diagnosis________________

Current Medications____

Allergies____

Parents / Legal Guardian Information

Parents/Guardian Names____

Home Phone______________________ Cell Phone______________________

Work Phone_______________________

Parent Email Address____

Caregiver Information

Caregiver Name(s)____

Days/Times/Locations____

Contact Phone Number(s)____

Emergency Information

Emergency contact________________________________ Phone______________________

Relationship to child____

PREGNANCY & BIRTH HISTORY

Did mother have any illnesses or complications during pregnancy or delivery? ☐ Yes ☐ No
Comments ____

Any medications, alcohol or other drug use during pregnancy? ☐ Yes ☐ No
Comments ____

At how many weeks was the child born_________________ Birth Weight____________

Did child require hospital stay or time in NICU? ☐ Yes ☐ No
Comments ____

Did your child require any medical procedures before, during or after birth? ☐ Yes ☐ No
Comments ____

Were there any complication with bottle or breast feeding? ☐ Yes ☐ No
Comments ____

Was your child bottle fed or breast fed and for how long?_______________________________

Did they have any colic or reflux issues? ☐ Yes ☐ No
Comments ____

MEDICAL HISTORY

Has your child experienced any of the following? *(please check all that apply)*

☐ Cleft Palate/Lip ☐ Seizures ☐ Frequent ear infections or fluid in the ears
☐ Feeding Tube ☐ Gastroesophageal Reflux ☐ PE Tubes (if so, when?______________)

Please describe illnesses, medical issues, or hospitalization that your child has had and when.
____
____

Has your child seen a specialist, or had other evaluations/testing?_________________________
____

Has your child received or is currently receiving other therapies?__________________________
____

Are there any other precautions we should know about that are not already described?
____
____

FAMILY INFORMATION

Family members in the home____

Languages spoken in the home____

Is there any known history of the following in the immediate or extended family?

 Autism/PDD ADHD Learning Disabilities
 Hearing Loss Stuttering Speech/Language Delays

HEARING & VISION

Has your child's hearing been recently evaluated? Yes No

*If yes, when, by whom and what were the results*________________________________

____

Is their vision within normal limits? Yes No

____

DEVELOPMENTAL MILESTONES

Please note when each of the following occurred.

Roll over__________

Crawl____________

Walk_____________

Sit Up__________

Was crawling phase brief? Yes No

Drink from a cup___________

Toiled Trained____________

Constipation or loose bowels? Yes No

Feed Self____________

What is the frequency of BMs?__________

Stomach aches? Yes No

SPEECH & LANGUAGE DEVELOPMENT

Please describe your child's primary mode of communication (gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange)?_________________________

____

If your child is talking, please indicate at what age your child began to:

Babble______ 2-3 word phrases________ First Words________

Use language as primary mode of communication:__________

How much of your child's speech do you understand?

 25% or less 25-50% 50-75% 75-100%

How much of your child's speech do others understand?

 25% or less 25-50% 50-75% 75-100%

Are there specific sounds your child has difficulty saying?________________________

Does your child demonstrate frustration when he/she is not understood? Yes No

*If yes, please explain*____

SELF HELP

Please describe how much assistance does child needs for:

Eating____

Dressing____

Toileting____

Bathing____

Washing hands & face____

Brushing teeth & hair____

BEHAVIOR & SOCIAL SKILLS

Follows verbal directions	☐ Yes	☐ No	Comment:
Initiates conversations	☐ Yes	☐ No	Comment:
Makes eye contact when speaking	☐ Yes	☐ No	Comment:
Has safety awareness	☐ Yes	☐ No	Comment:
Is impulsive or a risk taker	☐ Yes	☐ No	Comment:
Displays aggression toward self or others	☐ Yes	☐ No	Comment:
Enjoys roughhouse play	☐ Yes	☐ No	Comment:

Please describe your child's personality____

____

____

What do you feel are your child's strengths?_____________________________________

____

____

Does your child have tantrums? ☐ Yes ☐ No If yes, how often?____________________

How do you handle discipline issues at home?____

____

____

What are used for motivators or incentives for positive behavior at home or at school?

____

____

Does child tend to play alone or with others?______________________________________

DAILY ROUTINE

What time does child go to bed on week nights?________ Weekends?_______________

Does child have difficulty falling asleep?____

Does child wake during the night? ☐ Yes ☐ No If so, how often?___________

For what reason?____

Does child tend to wake with difficulty or refreshed?_______________________________

How well does your child handle transitions/changes in routine?____________________

____

What are child's favorite toys/activities?____

How well does your child organize/keep track of belongings?_______________________

EATING & DIET

Is your child a picky eater?	☐ Yes	☐ No	Comment:
Are they on a special diet?	☐ Yes	☐ No	Comment:
Do they have any food allergies or intolerances?	☐ Yes	☐ No	Comment:
Do you feel they get enough to eat and has a balanced diet?	☐ Yes	☐ No	Comment:

Please explain what your child typically eats for meals throughout the day.

Breakfast____

Lunch____

Dinner____

Snacks____

EDUCATION

Name of School_______________________________ Grade____________________

Teacher_____________________ Weekly schedule:_____________________________

Type of classes ☐ Regular ☐ Special Education ☐Life Skills ☐Other

Do you have any academic concerns?____

Is child satisfied with school?__________home?_____________friends?____________

If your child is not in school, where do they stay during the day?_________________

What are your goals/what do you or your child hope to gain from therapy?____________

____

____

____

Thank you for taking the time to complete this form!