**info@allcaretherapyservices.com**

# CHILD INTAKE PACKET

Client Name:_______________________________________________Date of Evaluation:____________________

Date of Birth:______________________________________________ Email Address:_________________________

Clients Address: _________________________________________________________________________________

Home Phone: ____________________________________ Mobile: _______________________________________

Guardian/Caregiver Name: __________________________________________________________________________

Relationship to Child: _____________________________________________________________________________

Reason for Referral: _____________________________________________________________________________

Referral Source: _________________________________________________________________________________

Physician: ________________________________________________ Phone#:__________________________________

Physician Address: _______________________________________________________________________________

## HEALTH/MEDICAL HISTORY:

Is your child in good health? _________________

If not, please describe medical issues: _________________________________________________________

_____________________________________________________________________________________________

Has your child been hospitalized? ________________________ If so, when and why_________________________

_____________________________________________________________________________________________

Does your child have a diagnosis? _________________________ If so, explain______________________________

_____________________________________________________________________________________________

Vision: Normal_____________ Impaired_____________ Wears Glasses _____________ Contacts_____________

Hearing: Normal____________ Impaired _____________Hearing Aid____________ Cochlear Implant__________

Has your child suffered from ear infections? Yes__________________ No___________________

If so, how many and at what age? _________________________________________________________________

_____________________________________________________________________________________________

Is Child: Verbal___________________________________ Non-verbal____________________________________

If child is non-verbal what is the primary mode of communication? _______________________________________

_____________________________________________________________________________________________

Does child have feeding difficulties? Yes_________________ No_________________

If so, please describe: ________________________________________________________________________

Does child have difficulty swallowing (i.e. g-tube, ng-tube)? Yes_________________ No_____________________

If so, please explain: _________________________________________________________________________

_____________________________________________________________________________________________

Does child have allergies? Yes___________________ No___________________

If so, explain: ______________________________________________________________________________

_____________________________________________________________________________________________

List all medications child has taken in the past or is currently taking (dosage and type):

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Does child employ specialized equipment at home (i.e. standers, bathing/toilet chairs, wheelchairs, strollers, feeding chairs, adaptive equipment, feeding utensils, etc.)?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Has your child ever had speech/occupational/physical therapy in the past? Yes___________ No____________

If so, when, where and duration? ST ____________________________________________________________

OT_________________________________________________________________________________________

PT_________________________________________________________________________________________

What goals would you like your child to achieve during physical/speech/occupational therapy?

___________________________________________________________________________________________

___________________________________________________________________________________________

**DEVELOPMENTAL HISTORY:**

Did your child exhibit any of the following behaviors during the first few years of life to a **noticeable degree**? Check only that applies and explain if possible.

Did not enjoy cuddling__________
Was not calmed by being held or stroked__________
Feeding difficulties__________
Did your child fail to gain weight or grow normally? __________

What ages did the following occur:

Sat alone________________________
Stood alone______________________
Began to babble__________________
Begin combining words____________
Walked unaided __________________
Dressed and undressed self __________

Crawled______________________________
Fed self with spoon_____________________
Produced first word_____________________
Taken off bottle_________________________
Taken off pacifier _______________________
Toilet Trained__________________________

**FAMILY HISTORY:**

Mother's name: ______________________________________________________ Age: ________________

Father's name: _______________________________________________________ Age: ________________

Siblings: Name Age Gender

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Is there a family history of developmental delays, speech problems, hearing loss, or learning problems?

______________________________________________________________________________

______________________________________________________________________________

**BIRTH HISTORY:**

What was the duration of the pregnancy? __________________________________________________

Did you experience any of the following during pregnancy? Please indicate yes/no
-Infections________________________________
-Toxemia_________________________________
-Surgeries_________________________________
-Alcohol consumption________________________
-Smoking__________________________________
-Other_____________________________________

Did you take any medications during pregnancy? Yes______________ No_______________

If yes, please list: ________________________________________________________________

______________________________________________________________________________

What type of delivery? C-section___________________________ or Vaginal _______________________________

Were there any complications during pregnancy? _______________________________________________

What was your child's birth weight? _________________________________________________

Were there complications during delivery? ____________________________________________

______________________________________________________________________________

Please indicate yes/no:

Forceps__________________________ Cord around neck____________________ Hemorrhage_________________

RH incompatibility___________________ Was your baby blue at birth_________________

Did your baby have breathing problems upon delivery? Yes_________ No_________

If yes, please describe______________________________________________________________

______________________________________________________________________________

Was your baby in an incubator? __________________Number of days_________________

Was your baby in the NICU? ____________________ Number of days_________________

**HOME/ PLAY/ SOCIAL BEHAVIORS:**

All children exhibit, to some degree, the kinds of behaviors listed below. Please check those that you believe your child exhibits to an excessive or exaggerated degree to compared to other children of similar ages.

Hyperactivity________

Impulsivity________

Tantrums________

Low frustration tolerance________

Reduced attention span________

Sloppy eating habits________

Interrupts frequently________

Does not listen when spoken to________

Sleep disturbances________

Reduced attention to danger________

Unusual fears (playground equipment, crowds, noises) ________

Does not learn from experience________

Head banging________

Drooling________

Eating inedible objects________

Poor memory________

Repeat activities for prolonged period of time________

Nightmares________

Whines frequently________

Destructive________

Staring episodes________

Accidents (falls, bumps into things) ________

Repetitive movements (hand waving, rocking, spinning) ________

What are your child's favorite toys? ___________________________________________________________

_________________________________________________________________________________________

What types of play activities does your child enjoy most? ___________________________________________

_________________________________________________________________________________________

What toys/activities does your child dislike the most? _______________________________________________

_________________________________________________________________________________________

What activities do you enjoy doing with your child? ______________________________

______________________________

Does your child play with other children? ______________________________

______________________________

**EDUCATIONAL HISTORY:**

School your child is attending: ______________________________

Grade: ______________________________

What feedback have you received about your child’s school performance? ______________________________

______________________________

______________________________