North Shore Children's Therapies

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Patient Intake Information

GENERAL INFORMAITON

Child's Name: _____ Date of Birth: _____
Parent (s) or Guardian (s) Names: _____
Address: _____
Home Phone: _____
Parent 1 Cell: _____ Parent 2 Cell: _____
Email address: _____
Emergency Contact Person: _____ Relationship to child: _____
Emergency Phone Number: _____
Other Children in the Family (names/ages):_____
_____
Is there a language other than English spoken in the home? _____
What language? _____ Does the child speak/understand this language? _____
Which is the preferred language of the home? _____
How did you hear about our practice? _____
Who referred your child for this evaluation? _____

SPECIALTY CONTACTS

Pediatrician's Name: _____ Name of Practice: _____
Pediatrician Address: _____
Pediatrician Office Number: _____ Fax Number: _____
Has your child received any other evaluations or treatment?

	Professional's Name	Date of Service
Neuropsychological		
Neurological		
Psychological		
Orthopedist		
Ophthalmologist/Optometrist		
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Audiologist		
ENT		
Other		

INSURANCE INFORMATION:

Insurance Carrier: _____ Insurance ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

MEDICAL INFORMATION:

List all allergies: _____

Medical Diagnoses (if any): _____

List any/all medication taken regularly: _____

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

_____

Has your child had their vision tested? : _____ Date: _____ Results: _____

Has your child had their hearing tested? : _____ Date: _____ Results: _____

Has your child had any of the following?

	No	Yes	Date	Additional Info
Childhood Illnesses				
Major Illnesses				
Congenital Abnormalities				
Surgery				
Serious Injury				
Ear Infections				
Tubes in Ears				
Allergies				
Seizures				
Other				

SCHOOL INFORMATION:

Name of school: _____

School location: _____

Present grade: _____

Hours of school: _____

Type of classroom: _____

Teacher/child ratio: _____

Services and frequency per week: _____

_____

Is your child keeping up at school? Does your child's teacher have concerns or comments?

_____

Does your child enjoy school?

_____

Which classes does your child especially likes/dislikes:

_____

Check any areas of difficulty or concern for your child:

_____ Reading
_____ Math
_____ Conduct
_____ Physical Ed.
_____ Completing work
_____Organization
_____ Paying Attention
_____ Following Directions
_____ Hyperactivity

BIRTH HISTORY:

History of pregnancy with this child (medication, health of mother, illness, infections, complications, etc.):

Is your child adopted? _____ Age of adoption: _____
Length of pregnancy (number of weeks): _____
Type of delivery (forceps/vacuum/C-section): _____
Condition of newborn: Weight: _____ Height: _____ Problems: _____
Were there any birth injuries? _____
Was Intensive care required? _____
Feeding: Method: _____ Problems: _____
Sleep (patterns, problems): _____

FAMILY HISTORY:

Is there a history of speech and language disorders in your family?

_____

Do you or anyone in your family have similar communication challenges to your child's?

_____

Do any of your family members have a diagnosis of Asperger's Disorder, Autism, or Pervasive Developmental Disorder (PDD)? _____

DEVELOPMENTAL MILESTONES: provide ages and comments if any

Say Words: _____
Say sentences: _____
Sat Unsupported: _____ Crawled: _____ Walked: _____

SPEECH THERAPY INTAKE

How does your child communicate? Please check all that apply.

speech ___ facial expressions___ gestures___ AAC device___ manual signs___

pointing___ vocalizations___ physically gets items him/herself brings caregiver to item___

What does your child use most often?

___gestures ___sounds ___1 or 2 words ___phrases ___complete sentences

Any adaptive equipment? _____

Please provide an example of a typical word/phrase/sentence that your child currently uses:

_____

How often does your child use speech? ____frequently ____sometimes ____rarely ____never

TELL ME MORE:

How long have you been concerned about your child's speech and language skills?

_____

What made you feel concerned at that time?

_____

What would you most like to gain from this evaluation?

_____

What particular skills would you like your child to develop?

_____

OCCUPATIONAL THERAPY INTAKE

Please list your primary concerns and reason for seeking and occupational therapy evaluation that you would like to be addressed in occupational therapy.

_____

_____

When did you first have concerns about your child?

_____

Please check if you or your child's teacher has concerns with any of the following:

Gross Motor

____ Strength ____ Sitting Posture ____ Balance

Fine Motor

____ Pencil Grasp ____Scissor Grasp _____ Hand Strength _____ Fine Motor Coordination

Visual Motor

____ Coloring _____ Writing ____ Drawing ____ Cutting ____ Spatial organization ____ Puzzles

Sensory Processing

____ Sounds _____ Sights _____ Touch ____ Movement _____ Smells

Sensory Based Feeding

_____ Texture tolerance _____ Temperatures _____ Smells

Developmental History:

How would you describe your child's activity level (reaction to being moved, degree of activity, child's favorite activity):

_____

Toilet training (age, duration, problems): _____

When did your child meet the following developmental milestones? (Please indicate age)

_____ Rolled _____ Sat unsupported _____ Crawled _____ Walked

_____ Used spoon _____ Used knife _____ Drank from cup

_____ Dressed shirt _____ Dressed pants _____ Used buttons _____ Used zipper

Do you have any concerns with your child's achievement of skills listed above? (which/why)?

_____

What do you hope to learn from this evaluation?

_____

What are your goals for therapy?

_____

CONSENT

Child's Name: _____ Date of Birth: _____

I, _____, Do hereby agree to give consent to North Shore Children's Therapies to furnish therapeutic services.

Parent/Caregiver Signature: _____ Date: _____

I, _____, give consent for North Shore Children's Therapies to bill my insurance company and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill.

Parent/Caregiver Signature: _____ Date: _____

I, _____, give consent for my child to use sensory tools during therapeutic services, including but not limited to swings, trampoline, huggy vests, weighted equipment etc.

Parent/Caregiver Signature: _____ Date: _____

I, _____, give permission for my child to participate in feeding therapy as part of their therapeutic services.

Parent/Caregiver Signature: _____ Date: _____