STEPPING STONES
Therapy & Learning Academy

# CHILD INTAKE FORM

To Parent/Guardian: Please answer the following questions about your child. **Please attach copies of the following documents:**

- Physical Therapy evaluations, hearing tests, vision tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).

| **CHILD'S INFORMATION** | | | |
|---|---|---|---|
| FULL NAME | | GENDER ☐ Male ☐ Female | DOB |
| CURRENT AGE | NAME OF SCHOOL | | GRADE |
| PRIMARY CARE PHYSICIAN (PCP) | | PCP PHONE | |
| DESCRIBE YOUR MAIN CONCERNS<br><br>Include <u>when</u> the problem was first noticed, <u>who</u> noticed it, and <u>where</u> the problem occurs. | | | |
| How does your child react to being misunderstood or unable to communicate? | ☐ Tries again/revises ☐ Becomes angry/frustrated ☐Other:<br>☐ Gives up ☐ Doesn't notice | | |
| Why are you seeking Physical/Occupational Therapy services for your child? | | | |
| Has your child's physician noticed these concerns? If yes, what were his/her recommendations? | | | |
| How did you learn about us? | | | |
| In the table to the right, list all other services your child has received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below. | TYPE OF SERVICE | DATES/AGE | NAME OF PROVIDER |
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|---|---|---|---|
| ☐ None | | | |

| **FAMILY'S INFORMATION** | | | |
|---|---|---|---|
| With whom does your child live? (Check all that apply) | ☐ Biological parent(s) ☐ Adoptive parent(s) ☐ Legal guardian(s) ☐ Grandparent(s) ☐ Sibling(s) ☐ Other: | | |
| In the table to the right, list all family members who live in the same home as your child. | NAME | AGE | RELATION TO CHILD |
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| Do you have any family pets? (List name and type) | | | |

| **PARENT 1 INFORMATION** | | | |
|---|---|---|---|
| FULL NAME | | GENDER ☐ Male ☐ Female | DOB |
| ADDRESS | | CITY | ZIP |
| PHONE 1 | ☐ CELL ☐ HOME ☐ WORK | EMAIL | |
| PHONE 2 | ☐ CELL ☐ HOME ☐ WORK | PREFERRED METHOD OF CONTACT | ☐ PHONE 1 ☐ EMAIL ☐ PHONE 2 |
| PLACE OF EMPLOYMENT | | POSITION | |

| **PARENT 2 INFORMATION** | | | |
|---|---|---|---|
| FULL NAME | | GENDER ☐ Male ☐ Female | DOB |
| ADDRESS | | CITY | ZIP |
| PHONE 1 | ☐ CELL ☐ HOME ☐ WORK | EMAIL | |
| PHONE 2 | ☐ CELL ☐ HOME ☐ WORK | PREFERRED METHOD OF CONTACT | ☐ PHONE 1 ☐ EMAIL ☐ PHONE 2 |
| PLACE OF EMPLOYMENT | | POSITION | |

| | | |
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| Are there family circumstances that would be helpful to share with your child's therapist? (e.g., custody arrangements) | | |
| Are there any other languages spoken in the home? If yes, which language(s) and how often? | | |
| Do any other family members have speech, language, or related difficulties or disorders? | RELATION TO CHILD | RELATED DIAGNOSIS/DISORDER |
| | | |

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|---|---|---|
| (e.g., ADHD, autism) | | |
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| CHILD'S HEALTH BACKGROUND | | | | |
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| Describe your pregnancy, including any complications. | | | | |
| Describe your labor/delivery, including any complications. | | | | |
| TYPE OF BIRTH (check all that apply) | ☐ Spontaneous (not induced) | ☐ Induced | ☐ Vaginal | ☐ C-section |
| BIRTH PLACE (hospital/birth center) | | BIRTH ATTENDANT (physician, midwife) | | |
| GESTATIONAL AGE (in weeks) | BIRTH WEIGHT | BIRTH LENGTH | NICU ☐ Yes ☐ No How long? | |
| Were there any complications after birth or during the first few weeks? | ☐ Difficulty breathing ☐ Difficulty feeding ☐ Birth defect<br>☐ Jaundice ☐ Seizures ☐ Other: | | | |
| Has your child's hearing been tested? ☐ Yes ☐ No If yes, when and where? | | | ☐ Passed ☐ Did not pass | |
| Describe any serious illnesses, injuries, or medical procedures your child has experienced. | | | | |
| List any environmental or food allergies. | | | | |
| List any routine medications your child is currently taking or has taken long term. | | | | |
| Describe any other conditions or diagnoses identified by your child's doctor or other professionals. | | | | |

| CHILD'S FEEDING DEVELOPMENT | | |
|---|---|---|
| BREASTFED from _____ months until _____ months | FORMULA FED from _____ months until _____ months | BOTTLE until _____ |
| At what age did your child begin using the following? | ☐ SIPPY CUP _____ months ☐ STRAW _____ months<br>☐ OPEN CUP _____ months ☐ UTENSILS _____ months | |

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| Describe any difficulties with sucking, swallowing, chewing, eating different textures, etc. | |

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| FAVORITE FOODS | FOOD AVERSIONS |

| **CHILD'S DEVELOPMENT** | |
|---|---|
| At what age did your child begin: | ☐ Rolling _____ months<br>☐ Sitting at _____ months<br>☐ Crawling (all fours) _____ months<br>☐ Walking _____ months<br>☐ Jumping _____ years |
| Please describe your child's activity level. (for example: moves around as if driven by a motor) | |
| Does your child seem overly sensitive to touch? Do they tend to lean on you? Do they seem to bump into things frequently? | |
| What are a few specific goals or skills you would like your child to attain in Physical/Occupational therapy? | |
| Has your child's physical development been evaluated before?<br>If yes, please note the place and summarize the findings. | |

| **CHILD'S STRENGTHS AND FAVORITES** | |
|---|---|
| Describe your child's strongest skills and personality traits. What makes your child unique? | |
| FAVORITE ACTIVITIES / HOBBIES | |
| FAVORITE TOYS | |
| FAVORITE MOVIES | |

| | |
|---|---|
| FAVORITE BOOKS | |

Thank you for taking the time to complete this information about your child.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE