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CLINICAL HISTORY & INTAKE FORM

Medical / Social / Behavioral / Developmental / Educational Information

PLEASE NOTE: *This form must be completed entirely and returned prior to scheduling your child's evaluation. Please indicate N/A if questions are not applicable.*

Child's Name: ____ **Today's Date:** ____________

Date of Birth: __________ **Age:** _____ **Gender:** Male ____ Female ____

Services Requested: OT___ PT___ Speech___ Behavior/Mental Health___

Social Skills ___ Feeding ___ Auditory Integration Treatment (AIT) ___ Unsure___

Other ____

How did you hear about the Center for Pediatric Therapy? ____________________________

Please take your time to thoughtfully complete this information. *The Clinical History & Intake Form* provides an overall "picture" of your child and is used by all disciplines (OT, PT, Speech, Behavioral and Social Skills) at the Center for Pediatric Therapy. We ask that you complete this information PRIOR to the first appointment. This will significantly reduce time by guiding the questions that need to be asked during the evaluation. It also guides the therapist regarding questions to ask (or not ask) initially as they develop a relationship with your child. We also realize there may be repetition of requested information on other questionnaires depending upon which therapy(s) your child is being evaluated for. Your tolerance is greatly appreciated.

THANK YOU for helping us get to know your child so we can develop a positive relationship and comprehensive treatment program.

Person(s) who completed this form: ____

Relationship to the child: ____

DIAGNOSIS:

List ALL diagnoses medical or otherwise
(i.e. ADD, ADHD, OCD, ODD, PDD, PDD-NOS, Asperger's Syndrome, Sensory Processing Disorder, Central Auditory Processing Disorder, Bipolar Disorder, Intellectual Disability, Cerebral Palsy, Esophageal Reflux, heart problems, visual impairment, learning disability, hearing impairment, anger issues, etc.)

- Confirmed Diagnosis: ____
____
- Questionable Diagnoses: ____
____

What are *your primary concerns*?
____
____
____

What are *your goals* for your child?
____
____
____

What is *your priority* to address in therapy?
____
____
____

What are your *child's strengths*?
____
____
____

THERAPY / TREATMENT HISTORY:

Is your child *currently* receiving any other therapy services? Yes____ No____
If so, what service(s)? ____
Where? ______________________________How Often?________________
Therapist name(s) ____

Has your child *previously* received any therapy services? Yes____ No____
If so, what service(s)? ____
Where? ______________________________How Often?________________
Therapist name(s) ____

IMPORTANT: ***If your child received insurance-based therapy elsewhere within your current insurance benefit year (calendar year or plan year), it may impact the remaining number of visits available on your plan for this benefit year. Failure to notify us of previously used visits may result in exceeding the visit limit and your insurance plan will deny payment. If we are not notified and your insurance denies the claim, you will be responsible for payment of our services.***

FAMILY INFORMATION and HISTORY:

- Mother's Name ____
  Address ____
  ____

  Phone (____) ____________ (home) (____) ____________ (cell) (____) ____________ (work) ext ______

  E-mail____ (optional)
  Employer/Occupation____

- Father's Name ____
  Address ____
  ____

  Phone (____) ____________ (home) (____) ____________ (cell) (____) ____________ (work) ext ______

  E-mail____ (optional)
  Employer/Occupation____

Primary Contact Person - Whom should we contact regarding your child's treatment; scheduling; appointment changes or financial arrangements?
____

Clearly indicate the **preferred telephone #** you want us to call for scheduling and/or appointment changes by writing #1, #2, #3 in priority order next to the phone numbers above.

Custodial Information: ☐ Not Applicable

- Is there currently a **legal custody order** in place? Yes___ No___
- Who does the child live with (most of the time)? ______________________
- What is the visitation schedule w/ other parent? ______________________
- Is there ANY legal restriction regarding sharing of information (clinical or financial) with the child's mother / father? (A copy of the court order may be required) Yes___ No___
  (Please explain): ____
  ____

- Stepmother's Name ____
- Stepfather's Name ____

- **Siblings:** Name(s) Age Gender

	Name(s)	Age	Gender
1.	______	______	______
2.	______	______	______
3.	______	______	______
4.	______	______	______

Family History: Does anyone in the child's family have any of the following issues?

	Yes	No	Who ?
Learning Disability			
ADD or ADHD			
Mental Retardation			
Mental Health issues			
Autism Spectrum Disorder (Asperger's, PDD)			
Speech and Language Delay			
Neurological Disorder			
Neuromuscular Disorder			
Sensory Processing Disorder/issues			
Substance Abuse			
Other			

MEDICAL HISTORY:

Primary Physician:

Name ______________________________ Phone ______________

Medical Practice Name ______________________________

Address ______________________________

List other applicable **doctors/specialists** your child *has seen* or *is seeing* (including Developmental Pediatrician, Pediatric Neurologist, Psychiatrist, Psychologist, Ophthalmologist or Developmental Optometrist, etc.):

Name ______________________________ Specialty ______________

Address______________________________

Name ______________________________ Specialty ______________

Address______________________________

Name ______________________________ Specialty ______________

Address______________________________

Allergies:

Does your child have any allergies? Yes___ No___

- Medication______________________________
- Food ______________________________
- Seasonal______________________________
- Other______________________________

Diet / Nutrition:

- Height: ________ Weight:_______
- Is your child on a special diet or have any dietary restrictions? Yes___ No ___
  (Please explain): ____
- Does your child have any eating issues including any of the following - loss of appetite; constant eating; recent weight loss/gain; limited food choices ("picky eater", avoids certain textures); diagnosed or suspected eating disorder (Anorexia, Bulimia); etc. (*Circle any that apply*)
  Please explain: ____
  ____
- Do you have any concerns about your child's nutritional intake? Yes___ No ___

Does/did <u>your child</u> have any of the following issues?

	Yes	No	Explain
Seizures			
Significant / high fevers			
Lead poisoning			
Asthma			
Sleep disturbances			
Snoring / sleep apnea			
Tonsils / adenoids removed			
Sexual concerns			
Bowel issues (beyond toilet training age)			
Bladder issues / bed wetting (beyond toilet training age)			
Childhood illnesses (list)			
Other			

Does your child have any **<u>medical precautions</u>** (related to diagnosis or medication)? Yes ___ No ___
(If yes, please explain): ____

Has your child had any operations? Yes ___ No ___
(If yes, please explain): ____

Medication: Does your child <u>currently</u> take any medication? Yes ___ No ___

Name of medication	Dose	Times per day	Purpose of medication	Prescribed by	How long on this med

Has your child experienced any side effects related to the medication? (i.e. sensitivity to sunlight, blood pressure changes, behavior changes, lethargy, increased activity level, appetite changes, etc.). Yes ___ No ___

(If yes, please explain): ____

Hearing:

- Has your child ever had his/her hearing evaluated? Yes ___ No ___
  (Include when, where, results): ____
- Does/did your child have frequent ear infections? Yes ___ No ___
- Did your child ever have myringotomy (ear) tubes? Yes ___ No ___
  (When? ______________ left? ___ right? ___)
- Does your child currently have ear tubes in place? Yes ___ No ___

Vision:

- Has your child ever had his/her vision evaluated? Yes ___ No ___
  (Include when, where, results): ____
- Has your child ever had eye surgery? Yes ___ No ___
- Has your child ever had vision therapy? Yes ___ No ___
  (Please explain): ____
  ____

BIRTH HISTORY:

Did you have any complications during pregnancy? Yes ___ No ___
(If yes, please explain) ____
____

Type of delivery? ___ Vaginal ___ C-section

Were there any complications during delivery? Yes ___ No ___
(If yes, please explain) ____
____

Was your child full term? Yes ___ No ___ Birth Weight: ________
If no, how many weeks early/premature? ________

Was your child hospitalized after birth (beyond typical hospital stay)? Yes ___ No ___

If, yes, how long? _______ Reason for hospitalization ________________________________

Did your child experience any medical, developmental or feeding issues as an infant?
Yes ___ No ___

(If yes, please explain) ____
____
____

DEVELOPMENTAL HISTORY:

Hand preference: left____ right____ switches ____

Does your child currently have difficulty with coordination skills?

- Gross motor difficulty (balance, jumping, running, climbing, etc.) Yes ___ No ___
- Fine motor (hand/finger dexterity, strength, etc.) Yes ___ No ___
- Handwriting difficulty Yes ___ No ___

Did your child have a very brief (or skipped) crawling stage? Yes ___ No ___

Motor Development Milestones	Age?	Comments
Rolled over		
Sat alone		
Crawled		
Stood alone		
Walked		

Speech /Language Development Milestones	Age?	Comments
Used his/her first word		
Combined 2 words		
Used complete sentences		

Describe child's current Receptive Language skills (comprehension, direction following, etc.)

____

____

Describe your child's current Expressive Language skills (speech intelligibility, vocabulary)

____

____

SELF-HELP / ADAPTIVE SKILLS:

Sleeping, Eating, and ADLs:

Does your child…	Frequently	Occasionally	Seldom	Never
Have difficulty falling asleep?				
Have rigid bedtime routines?				
Have limited food choices (picky eater)?				
Have difficulty chewing or swallowing?				
Need help with dressing/undressing?				
Resist during grooming (brushing teeth, washing hair, haircuts, nail clipping, etc.)?				

Comments: ____

____

EDUCATIONAL HISTORY:

What school district do you live in? ____

Infant / Pre-school Age:

- What pre-school does your child attend? _____________________________________
- What daycare does your child attend? ____
- Does your child attend a BCIU pre-school classroom? Yes ___ No ___
- What days does he/she attend pre-school/daycare/BCIU? (circle) M T W Th F
- What hours does he/she attend? ____

School-Age:

- What school does your child attend? ____
- What grade is he/she in? ______ Teacher ___________________________________
- Does your child attend a before or after school program? Yes ___ No ___
- Extra-curricular activities____

Academic Area(s) of strength:

____

____

Academic Area(s) of need:

____

____

How would you describe your child's overall school performance (grades)?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you describe your child's overall school experience (likes or dislikes school)?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you describe the stress level during homework time? (your child's and yours)

☐ Not stressful ☐ Minimally ☐ Moderately ☐ Very Stressful

Has your child ever been evaluated by the school for any specific

Yes ___ No ___

concerns or additional services?

Does your child have an *Individualized Educational Plan* (IEP), *Gifted IEP* (GIEP) or *Service Agreement* (504 Plan) in place? Yes ___ No ___

Does your child receive any specialized instruction or accommodations at school? (If yes, please explain) ____ Yes ___ No ___

____

Does your child spend any point of the school day in a specialized classroom?

(Resource Room, Learning Support, Emotional Support, Autistic Support, Life Skills, etc.) Yes ___ No ___

(If yes, please explain) ____

____

Are there any other issues that impact school performance?

(Behavioral; attention; learning; social; attendance, etc.): Yes ___ No ___

(If yes, please explain) ____

____

EMOTIONAL / BEHAVIORAL HISTORY:

Please check the boxes below that best describe your child.

Emotional/Behavioral Skills:	Good	Fair	Poor	Comments
Cooperation				
Motivation				
Frustration level				
Impulsivity				
Response to limit setting				
Safety awareness				
Coping skills				
Tolerance for change in routine or plans				
Self esteem				
Separates from parent or familiar adult				

Tantrums: Frequency ☐ never ☐ seldom ☐ occasionally ☐ frequent
Intensity ☐ mild ☐ moderate ☐ severe
Average # of "meltdowns" per day ____ per week ____

Aggression: ☐ verbally (**circle if applicable:** *loud / yell / scream / cry / say hurtful things*)
☐ physically (**circle if applicable:** *hit / kick / bite / spit / pinch / slam doors / throw objects / tear papers / damage property / other*: ____________________________________)

Does your child have any:

- Ideation of self-harm ☐ Yes ☐ No explain: ____________________________________
- Self-injurious behaviors ☐ Yes ☐ No explain: ____________________________________
- Self-stimulatory behaviors ☐ Yes ☐ No explain: ____________________________________
- Excessive fears ☐ Yes ☐ No explain: ____________________________________

What helps to calm your child? ____

Do you feel that any of your child's behaviors interfere with his/her ability to function in daily activities and routines? Yes ___ No ___

(If yes, please explain) ____

What is the most <u>challenging</u> part(s) of your child's daily routine?

____

What is the most <u>pleasurable</u> part(s) of your child's daily routine?

____

SOCIAL & PLAY SKILLS:

Social Interaction:	Good	Fair	Poor	Comments
Makes friends easily				
Maintains friendships				
Initiates & maintains conversation				
Maintains social distance				

Play Skills:	Good	Fair	Poor	Comments
Plays w/ toys appropriately				
Plays/entertains self				
Initiates play				
Allows others to join play				
Shares w/ others				
Plays creatively w/ toys				
Imitative play				
Participates/cooperates in clean-up				

Play Style:
- ☐ Age appropriate / variety / combination of active & sedentary play
- ☐ "Dump and go"
- ☐ Demands attention while playing
- ☐ Dominates or attempts to control others during play
- ☐ Rough or destructive w/ toys
- ☐ Prefers to play alone
- ☐ Gets frustrated easily during play

Preferred activities, interests, toys or hobbies (including clubs, sports, church, community, etc.):

___
___
___

Fear or dislike of any specific toys, activities, animals, people: (i.e. loud, sudden or unpredictable motions or sounds; appearance)

___
___
___

Is there any other information about your child that you feel would be helpful for us to know?
(Please explain – include additional pages if needed):

___
___
___
___
___
___
___

THANK YOU for helping us to understand your child!