Children's Therapy Center, Inc.

childrenstherapyctr.com

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Evaluation Intake Questionnaire

Patient's Name:_____ Birthdate (dd/mm/yyyy):_____

Gender: ☐ Male ☐ Female ☐ Prefer not to specify

Person Completing Form: _____ Today's Date: _____

Intake Information	
Why were you referred for an evaluation? Check all that apply.	☐ Fine motor ☐ Gross motor ☐ Sensory ☐ Mobility ☐ Speech clarity ☐ Language ☐ Social skills ☐ Swallowing ☐ Feeding ☐ Stuttering ☐Behavior
Which therapies are you requesting? Check all that apply.	☐ Occupational Therapy ☐ Physical Therapy ☐ Speech and Language Therapy ☐ Feeding Therapy
Explain your reasons for pursuing this evaluation and treatment priorities:	
Does your child have any medical diagnoses? If yes, please indicate the date of diagnosis and the name of the provider who made the diagnosis. *provide additional information in the space above.	☐ No ☐ Yes Diagnosis:_____ Date:_____ Provider: _____ Diagnosis:_____ Date:_____ Provider: _____ Diagnosis:_____ Date:_____ Provider: _____
Is your child regularly followed by other specialties? If yes, please list. *provide additional information in the space above.	☐ No ☐ Yes Provider & Specialty:_____ Clinic:_____ How often are they seen? _____ Provider & Specialty:_____ Clinic:_____ How often are they seen? _____ Provider & Specialty:_____ Clinic:_____ How often are they seen? _____

Will interpreter services be required for the evaluation?	☐ No ☐ Yes
What is the child's primary language(s)? Are other languages spoken in the home? If yes, please list.	Primary Language:_____ ☐ No ☐ Yes: _____ _____

Therapy Precautions	
Does your child have any known allergies (i.e. food, latex, environmental)? If yes, please list the allergy type, when and where diagnosed, and response to exposure.	☐ No ☐ Yes: _____ _____ _____ _____ _____ _____ _____
Does your child have any dietary requirements or other therapy precautions you would like us to be aware of? (e.g. vegetarian, halal diet, etc.)	☐ No ☐ Yes: _____ _____ _____
Is your child on any medications? Please list.	☐ No ☐ Yes Medication: _____ Dosage:_____ Date initially prescribed:_____ Medication: _____ Dosage:_____ Date initially prescribed:_____ Medication: _____ Dosage:_____ Date initially prescribed:_____ Medication: _____ Dosage:_____ Date initially prescribed:_____
Is your child up to date on vaccinations?	☐ No ☐ Yes
Have you chosen to opt-out of vaccinating your child?	☐ No ☐ Yes
Does your child have Atlantoaxial Instability or restrictions for weight bearing?	☐ No ☐ Yes: _____ _____
Does your child use adaptive equipment? (e.g. hearing aids, gait trainer, AFOs, forearm crutches, cochlear implants)	☐ No ☐ Yes, please describe _____ _____ _____
What is your child's primary mode of communication? Check all that apply.	☐ Verbal ☐ Sign ☐ Speech generating device ☐ Gestures ☐ Other:_____

Family Information	
Caregiver 1	Name: Relationship to child: Date of birth (mm/dd/yyyy):

Caregiver 2	Name: Relationship to child: Date of birth (mm/dd/yyyy):
Other caregivers	Name: Relationship to child: _____ _____ _____ _____ _____ _____
Are primary caregivers:	☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Living together ☐ Remarried
Besides caregivers listed above, who lives in the home with the child? Please list names and dates of birth of children:	
Is the child adopted? If so, provide age adopted and birth location:	☐ No ☐ Yes Age adopted: Birth location:
Is the child in foster care? If so, provide the date of placement and pertinent information regarding biological parents.	☐ No ☐ Yes Placement date: Additional info:
Is there an immediate or extended family history of any of the following? Check all that apply:	☐ ADHD ☐ Dyslexia ☐ Autism/PDD ☐ Hearing Loss ☐ Stuttering ☐ Communication Disorders
Please indicate holidays your family observes.	☐ Valentine's Day ☐ Saint Patrick's Day ☐ Easter ☐ Halloween ☐ Thanksgiving ☐Christmas ☐ Hanukkah ☐ Kwanzaa ☐ Cinco de Mayo ☐ 4th of July ☐ Mother's Day ☐ Father's Day ☐ Ramadan ☐ Diwali ☐Additional:_____

Birth History	
Were there any complications during pregnancy?	☐ No ☐Yes _____ _____ _____
Were drugs or medications taken during pregnancy?	☐ No ☐ Yes,_____ _____ _____
Was this pregnancy full term?	☐ No ☐ Yes Gestational age:
Delivery	☐ vaginal ☐ caesarian Hospital: _____ Birthing Center: _____ Home Birth:_____

Complications during delivery?	☐ No ☐ Yes _____ _____ _____
Weight at time of delivery:	_____ pounds _____ ounces
Apgar scores (if known):	
Did your child require a stay in the NICU? If yes, how long?	☐ No ☐ Yes_____ _____
Did your child experience respiratory difficulties?	☐ No ☐ Yes
Did your child experience jaundice?	☐ No ☐ Yes
Did your child experience initial feeding difficulties?	☐ No ☐ Yes, please describe _____ _____ _____ _____

Medical History	
Has your child had any of the following? Please check those that apply.	☐ Seizures ☐ Head injury ☐ High fevers ☐ Respiratory illness ☐ Asthma ☐ Sinusitis ☐ Sleeping difficulties ☐ Cleft palate ☐ immunodeficiency ☐ Tonsillitis ☐Tonsillectomy ☐ Adenoidectomy ☐ Sucking thumb/fingers/pacifier ☐ Constipation issues ☐ Meningitis ☐ Measles ☐ Chickenpox ☐ Other:_____
Has your child had or knowingly been exposed to the CMV virus?	☐ No ☐ Yes
Has your child had any of the following? Please check all that apply.	☐ G-tube ☐ Swallowing difficulties ☐ Reflux ☐ Feeding difficulties ☐ Food avoidances ☐ Video swallow study
Does your child wear glasses? Does your child have a history of vision problems?	☐ No ☐ Yes ☐ No ☐ Yes, please describe: _____ _____ _____
Has your child had a vision assessment? If yes, when and where was the most recent vision assessment?	☐ No ☐ Yes Date: _____ Location: _____ Results:_____
Has your child had a hearing evaluation? If yes, when and where was your child's most recent hearing evaluation?	☐ No ☐ Yes Date: _____ Results:_____ Audiologist:_____ Clinic:_____
Does your child have a history of ear infections or middle ear fluid?	☐ No ☐ Yes Age of first infection:_____ How many have they had? _____
Has your child had ear tubes?	☐ No ☐ Yes How many sets? _____

Please describe any pertinent medical conditions not mentioned above.	

Growth and Development	
What age did your child…	
Roll from stomach to back:	Use feeding utensils:
Roll from back to stomach:	Drink from open cup:
Sit independently:	Dress independently:
Belly crawl:	Toilet trained:
Crawl on hands/knees:	Toilet trained through the night:
Stand independently:	Babble:
Cruise furniture:	Speak first word:
Walk independently:	Speak 2 word sentences:
Check all of your child's current motor skills	☐ Jump up and down ☐ Hop on one foot ☐ Skip ☐ Catch a ball ☐ Kick a ball ☐ Climb/descend stairs alternating feet
Hand preference	☐ Right ☐ Left ☐ Uses both hands equally
Check all that describe your child	☐ Overly active ☐ Tires easily ☐ Clumsy ☐ Impulsive ☐Resistant to change ☐ Unusual fears ☐ Frequent tantrums ☐ Tics ☐ Nervous habits ☐ Sensory seeking behaviors ☐ Poor attention span
Are your child's behaviors easily managed by caregivers?	☐ Yes ☐ No, please describe:_____ _____ _____
Does your child…? (check all that apply)	☐ Empathize with others' feelings ☐ Understand consequences ☐ Understand praise/reward ☐ Recognize danger ☐ Draw attention by pointing ☐ Follow directions ☐ Participate in imaginative play ☐ Make eye contact ☐ Show affection to familiar caregivers ☐ Have difficulty separating from caregivers

Educational Background	
Does your child attend school?	☐ No ☐ Yes School:_____ Grade:_____ Teacher name:_____ Teacher's email:_____

Does your child receive the following therapies in school? Provide information for all that apply.	Special education: ☐ No ☐ Yes Direct/indirect minutes per week:_____ Teacher:_____ Teacher's email:_____ Occupational therapy: ☐ No ☐ Yes Direct/indirect minutes per week:_____ Therapist:_____ Therapist's email:_____ Physical therapy: ☐ No ☐ Yes Direct/indirect minutes per week:_____ Therapist:_____ Therapist's email:_____ Speech therapy: ☐ No ☐ Yes Direct/indirect minutes per week:_____ Therapist:_____ Therapist's email:_____ Other: ☐ No ☐ Yes Specialist:_____ Specialist's email:_____
May we communicate with the school staff?	☐ No ☐ Yes
Does your child currently receive outpatient therapy services, or have they received them in the past? If so, please describe.	Clinic name:_____ Services (check all that apply): ☐ PT ☐ OT ☐ SP Time frame of services received:_____ Clinic name:_____ Services (check all that apply): ☐ PT ☐ OT ☐ SP Time frame of services received:_____

****Thank you for completing this form.** We understand that this is a lot of information. We require that it is returned to the clinic at least **2 days prior to the assessment.** This information is pertinent to the assessment process. It allows us to be able to spend as much time as possible with your child during your scheduled time. It will help us complete the assessment process more accurately and completely.