

Please take a few minutes to fill out this form as completely as possible.

Child's Name: _____ Gender: _____ Date of Birth: _____ Age: _____

Name of Individual Completing Intake Form (Printed): _____

Date Completed: _____ Relationship to Child: _____

Current Medications: _____

Allergies (Food/Medication): _____

Medical restrictions / precautions: _____

Name of Child's School/Daycare: _____ Grade Level (if applicable): _____

Special interests / hobbies of the child: _____

BIRTH HISTORY

How many weeks? _____ ☐ Singleton ☐ Twin A ☐ Twin B

Duration of Labor: _____ Delivery: ☐ Natural ☐ Cesarean ☐ Labor Induced

Birth mother's health / conditions / drug use / medications: _____

Pregnancy / Delivery Complications: _____

Birth weight: _____ Birth height: _____ APGAR Scores: 1 min _____ 5 min _____

NICU Length of Stay (if applicable): _____ Feeding tube: _____ Respiratory/Oxygen: _____

Other details / information: _____

MEDICAL / SURGICAL HISTORY

Medical condition(s) / diagnosis: _____

Surgeries, illnesses, hospitalizations, genetic conditions: _____

Any previous/current problems with (please select):

	YES	NO	If YES, please describe (frequency, treatment, hospitalization/date, etc.):
Head			
Eyes			
Ears			
Nose			
Throat			
Respiratory System			
Asthma			
Heart / Vascular System			
Digestive Tract			
Constipation			
Liver (Hepatits, etc.)			
Genito-Urinary Tract			
Bones / Muscles			
Hormones			
Brain or nerves			
Seizures			
Sleep			
Appetite / Nutrition			
Fevers / Colds			
Infectious Conditions			
GERD / Reflux			

AREAS OF CONCERN / GOALS

What brings you here? What concern(s) / goal(s) do you have (developmental, educational, social, behavioral, etc.)?

Any Previous PT, OT, or Speech Therapy? _____ YES _____ NO

If YES, please describe (services, name of therapy facility / group, etc.): _____

Is there anything else we should know about your child / their family?
