

Legal name: First _____ MI _____ Last _____
Date of Birth _____ Gender Male _____ Female _____
Diagnosis, if any _____

PARENT CONCERNS

Reason for evaluation _____

Please check any areas of development that you have a concern about:

- Attention
- Eating/feeding
- Hearing
- Behavior
- Mobility
- Touch
- Nutrition
- Play
- Sleeping
- Speech/Language
- Temper tantrums
- Vision
- Weight/growth
- Motivation
- Ability to calm themselves
- Movement
- Hand use

MEDICAL HISTORY

Pregnancy proceeded: Normally _____ With complications _____
Indicate complicating conditions _____

Circle any that apply

Gestational diabetes _____ Toxemia _____ Pre-eclampsia _____ Eclampsia _____ Multiple births _____
Substance exposure _____ Positive for strep B _____ Positive for cytomegalovirus (CMV) _____
Premature labor _____ Other: _____ Length of pregnancy: _____ Weeks _____
Prenatal care was: Received _____ Not received _____
Mother's age at time of birth: _____ Yrs
Length of stay: _____ Days Delivery was: Vaginal _____ C-Section _____ Emergency C-Section _____

Complications during delivery: premature rupture of membranes _____ Breech presentation _____
Placenta previa _____ Abruptio placenta _____
Use of forceps _____ Uterine rupture _____
Transverse presentation _____ Prolapsed cord _____
Umbilical cord wrapped around the neck _____
Other: _____

Birth weight was: _____ Lbs. _____ Oz. Birth length was: _____ Ins.
Apgars: 1 minute _____ 5 minute _____ 10 minute _____

Were there significant complications following birth: Yes _____ No _____

Indicate significant complications:

Meconium aspiration _____ Respiratory distress syndrome _____ Respiratory stridor _____
Neonatal hypoxia _____ Club foot _____ VP shunt _____ PDA _____
Positive dependency _____ Failure to thrive _____ Cytomegalovirus _____ Cleft lip and/or Palate _____
Respiratory syncytial virus (RSV) _____ Hyperbilirubinemia _____ ECMO _____

Anemia of prematurity Retinopathy of prematurity (ROP) IVH Bleed Oxygen
dependency Brochopulmonary dyspasia (BPD)
Ventilator dependency Intrauterine growth retardation (IUGR) Other:
Diagnosed / suspected syndrome _____

Health issues

Chronic ear infections Sleep problems Traumatic brain injury (TBI)
Cerebral vascular accident (CVA) Anoxic brain injury
Asthma / respiratory Arteriovenous malformation (AVM)
Reflux Colic Constipation / diarrhea
Tube feeding Seizure disorder (date of last seizure _____)
Allergies please list:

Current medications _____
Homeopathic _____

Hearing tested YES NO Results _____
Date: (mo/yr) _____

Vision testing YES NO Results _____
Date: (mo/yr) _____

Specialists Seen:

| | | | |
|--------------------|--------------|------------------|------------------------|
| Cardiologist | Allergist | Oncologist | Endocrinologist |
| Orthopedic Surgeon | ENT | Pediatrician | General Surgeon |
| Physiatrist | Hand Surgeon | Podiatrist | Internal Medicine |
| Rheumatologist | Neurologist | Thoracic Surgeon | Neuro-Surgeon |
| Urologist | Psychiatrist | Audiologist | Gastroenterologist |
| Ophthalmologist | Nephrologist | Geneticist | Developmental Medicine |

Name of specialist(s) currently following your child:

Ever had any of the following:
Swallow Study (Date and place) _____
BAER (Date and place) _____
MRI/CT Scan/X-RAY (Date and place) _____

List any previous surgeries: (indicate age at time of surgery)
Age: Surgery:
Age: Surgery:

DEVELOPMENTAL HISTORY

Motor, Sensory, Play

At what age did your child: Age (optional if child is over 10 years of age)

| |
|---|
| Hold head up alone |
| Roll over |
| Sit alone without support |
| Crawl / creep alone |
| Pull self to standing position |
| Walk unaided |
| Grab toy |
| How does your child get around at home? |
| Does child fall or lose balance easily? Yes No |
| Is your child |
| Right-handed Left-handed Neither |
| Does your child visually look at people and/or toys? Yes No |
| Does your child show a negative response when touched or when touching other objects? Yes No |
| Does your child enjoy movement such as swinging or roughhousing? Yes No |
| What are your child's favorite toys and/or play activities? |
| Does your child play and/or participate in leisure activities daily? Yes No |
| Is your child involved in community programs (school, special rec., scouts, etc.)? Yes No |

FEEDING, SPEECH and LANGUAGE

| |
|--|
| Does your child have any feeding problems? Yes No |
| Please describe: |
| When did your child: Age (optional if child is over 10 years of age) Age |
| Stop using a bottle |
| Name familiar objects |
| Stop using a pacifier Use two-word combinations |
| Begin using a cup, sippy cup, straw |
| Begin eating - Baby food Finger Food Table Food |
| List Food Preferences |
| Dislikes |
| Check areas of difficulty, if any: |
| Chewing Swallowing Drooling |
| Drooling |
| Understanding words Communicating needs |
| How does your child communicate his/her needs? |
| Verbal Communication: Non-verbal Communication: |
| Vocalizations Facial expression Body language |
| Single words Pointing / gestures Manual sign language |

| | | | | |
|---|--|----------------------|-----------|----------|
| Phrases | Eye gaze | | | |
| Sentences | Augmentive Communication System (explain): | | | |
| What were your child's first words? | | | | |
| Do most people understand your child's speech? | Yes No | | | |
| Does your child understand instructions? | Yes No | | | |
| Please check any of the following that currently describe your child: | | | | |
| Affectionate | Motivated | Difficult to Comfort | Playful | Cautious |
| Aggressive | Curious | Fearful | Shy | Passive |
| Active | Demanding | Fearless | Stubborn | Fussy |
| Calm | Distractible | Persistent | Withdrawn | Insecure |

School History

| |
|--|
| If your child is in school, what grade:Where: |
| Does your child have an IEP from school? Yes No |
| (Please include a copy of the most recent IEP with this intake packet) |
| Has your child had a psychological or neuropsychological evaluation completed? Yes No |
| (Please include a copy of the most recent psychological or neurological evaluation) |
| |

Therapy History

Has your child ever received any of the following services? YES NO

| | | | | |
|---------------------------|------------|-------|--------------------|-------|
| Physical Therapy | Individual | Group | Location | Dates |
| | | | Therapist/Provider | |
| Occupational Therapy | Individual | Group | Location | Dates |
| | | | Therapist/Provider | |
| Speech / Language Therapy | Individual | Group | Location | Dates |
| | | | Therapist/Provider | |
| Social Work | Individual | Group | Location | Dates |
| | | | Therapist/Provider | |
| Assistive Technology | | | Location | Dates |
| | | | Therapist/Provider | |
| Nutrition | | | Therapist/Provider | |
| Vision Therapy | | | Location | Dates |
| | | | Therapist/Provider | |
| Audiology | | | Location | Dates |
| | | | Audiologist | |
| Behavior Therapy | | | Location | Dates |
| | | | Therapist/Provider | |
| Developmental Therapy | | | Location | Dates |
| | | | Therapist/Provider | |