

Therapy History Intake Form Challenged Child and Friends

Patient Information						
Name: _____	Date of Birth: _____	Race: _____	Gender M F	Diagnosis: _____		
Address: _____						
Referring Physician: _____		Address: _____		Phone Number: _____		
Mother: _____			Father: _____			
Phone Number: _____			Phone Number: _____			
Email: _____			Email: _____			
Reason for referral (check all that apply)						
Academic <input type="checkbox"/>	Attention difficulties <input type="checkbox"/>	Hearing <input type="checkbox"/>	Reading <input type="checkbox"/>	Stuttering <input type="checkbox"/>	Difficult to understand <input type="checkbox"/>	Does not follow commands <input type="checkbox"/>
Does not communicate wants/needs <input type="checkbox"/>		Is not talking yet <input type="checkbox"/>		Other: _____		

Intervention History	
Currently receiving the following therapy? OT _____ ST _____ PT _____	Where and frequency _____
History of the following therapy? OT _____ ST _____ PT _____	Where and frequency _____
Currently being served by an Individual Educational Plan (IEP) or Babies Can't Wait? YES NO	

Educational/Preschool/Nursery History
Current and/or past nursery, preschool(s) and/or school(s) settings (if any)? _____ _____ _____

Family Information		
Persons living in the home:		
Name	Age	Relationship

Maternal/Labor & Delivery/Medical History		
Mother's age at time of delivery? _____		
Maternal History	YES	NO
Problems, conditions and/or diseases during pregnancy? _____		
Medications during pregnancy? _____		
Drug/alcohol use during pregnancy? _____		
Comments: _____		
Labor & Delivery	Answers/Comments	

Weeks of gestation at time of delivery?							
Length of labor?							
Was labor induced?	YES _____ NO _____						
Type of delivery?	Vaginal _____ C-Section _____						
Neonatal History							
Birth weight _____							
History		YES	NO	Comments			
Anything exceptional in his/her condition?							
Ability to suck/swallow?							
Breast fed?							
Bottle fed?							
Did he/she have problems after birth							
Did he/she spend time in the NICU?							
Milestones							
Milestones		Approximate Age		Comments			
Held head up							
Sitting up							
Crawled							
Pulled up							
Walked							
First words							
Additional Medical History							
History		YES	NO	History		YES	NO
Ear infections				Visual problems			
Hearing problems				Neurological disorder			
Developmental disorder				Speech difficulties			
Difficulty swallowing				Cleft lip/palate			
Tongue deformity				Jaw deformity			
Ear deformity				Pressure equalization tubes			
Wax build up				Chronic cough/colds			

Check all conditions that apply to your child:						
Allergies <input type="checkbox"/>	Asthma <input type="checkbox"/>	Seizures <input type="checkbox"/>	Heart Problems <input type="checkbox"/>	Apraxia <input type="checkbox"/>	Gastrointestinal <input type="checkbox"/>	Other: _____
Current daily medications and dosage: _____						
Accidents/Illnesses/Surgeries: _____						
Date of most recent vision test: _____			Where was it done? _____			
Date of most recent hearing test: _____			Where was it done? _____			
If your child has been seen by a medical specialist, hospital, clinic, agency, etc., please list below:						
Agency/Specialist: _____		Date: _____		Agency/Specialist: _____		Date: _____
Address: _____			Address: _____			
Tests completed: _____			Tests completed: _____			
Results/Recommendations: _____			Results/Recommendations: _____			

Present Level of Communication		*Speech Therapy Evaluation	
Describe your concerns about your child's speech, language, swallowing and/or hearing: _____			
When listed concerns were first identified? _____			
What do you expect from this evaluation? _____			
Please indicate all means of communication currently used:			
Speech <input type="checkbox"/> Facial Gestures <input type="checkbox"/> Gestures <input type="checkbox"/> Signing <input type="checkbox"/> Communication device <input type="checkbox"/> Bodily gestures <input type="checkbox"/> Pointing <input type="checkbox"/> Other: _____			
List any adaptive equipment currently used: _____			

What were your child's first words? _____

Approximately how many words did your child have at 18 months? _____

24 months? _____

At what age did your child say his/her first sentence? _____

Please give some examples of first sentences:

Please give an example of typical sentences your child currently uses:

How often does your child use speech? Frequently Sometimes Rarely

How does your child make his/her needs known? _____

Does your child use gestures often? YES NO

If so, give examples:

What does your child use the most?

Gestures Sounds One or two words Phrases Complete sentences

Estimate the percentage of time that your child is understood by:

Parents	%	Siblings	%	Peers	%	Unfamiliar adults
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How well does your child understand what is said to him/her?

Please indicate your child's current level of understanding by checking those that apply:

Understands Gestures Does not understand spoken words Understands simple words

Understands simple sentences Understands 2 and 3 part commands Understands conversation

Do you think your child is aware of his/her communication difference? YES NO

If yes, please describe how he/she shows awareness:

Provide any other information about your child's communication that is of concern to you.

What have immediate family and/or relatives done to help your child overcome his/her communication difficulty?

Has this helped? _____

What do you think caused this communication difference?

Please provide any additional information you feel will help us in understanding your child and his/her present communication ability.

Self Care/Self Help Skills		* Physical/Occupational Therapy Evaluation		
Task	YES	NO	NA	Comments & level of assistance needed
Still in diapers?				
Independent in toileting?				
Able to indicate need to use restroom?				
Independent with self feeding?				
Independent with utensils?				
Able to suck through a bottle/Sippy cup?				
Able to drink from open cup				

independently				
Able to suck through straw?				
Able to sit independently at table?				
Able to don/doff shoes and socks independently?				
Able to don/doff jacket independently?				
Able to pull up/down pants independently?				
Able to button/zip pants independently?				
Able to wash hands independently?				
Able to verbalize and/or indicate needs?				

Fine Motor Skills ***Physical/Occupational Therapy Evaluation**

Grip type: ___Pincer ___Palmer ___Tripod ___Raking (observed via therapist)
 Hand dominance: ___Right ___Left ___Not established/NA

Task	YES	NO	NA	Comments & Level of Assistance Needed
Able to manipulate objects/toys in hands (Bilaterally)?				
Able to reach for objects in all planes?				
Able to grasp and release objects?				
Able to cross midline during play?				
Displays appropriate arm-extension protective righting reaction (front, back, and sideways)				
Able to tear, snip, and/or cut paper?				
Able to imitate strokes, scribbles, and/or draw?				
Able to build 3 block tower independently?				
Able to Count from 1-10?				
Able to recognize colors?				
Able to recognize shapes?				

Gross Motor ***Physical/Occupational Therapy Evaluation**

Task	YES	NO	NA	Comments
Use of any devices? (Walker, chair, etc.)				
Any history of presence of walking difficulties?				
Falls frequently?				
Able to jump, hop, skip?				
Able to ascend/descend stairs appropriately?				

A concern for your child's sensory processing?

Additional Information
