Client Intake Form

Childs Name: _____ Date of Birth: _____
Address: _____
_____E-Mail: _____
Phone: _____Cell Phone: _____
Parent/Guardian Names: _____
Child lives with both parents? Yes____ No____
Names and ages of siblings: _____
_____
Pediatrician: _____ Phone: _____
Reason for referral/Referral source: _____
Medical conditions/diagnosis: _____
Previous evaluations (list) _____
Therapy to date (list) _____
Describe present concern/problem_____
_____
Who noted present problem? _____ When? _____
Have there been any significant changes in the past six months? _____
If so, what? _____

**Prenatal/Birth History**
Full Term: Yes _____ No_____ If no, how many weeks?_____
Birth Hospital: _____
Illnesses or accidents during pregnancy: _____
Use of alcohol, tobacco or medications during pregnancy: _____
Birth weight: _____ Delivery: Vaginal___ Cesarean___ Breech___ Feet First____
Other unusual conditions that may have affected pregnancy or birth? _____
_____

**Medical History**
Please check if your child has had any of the following (and if so, at what age):

| | | | |
|---|---|---|---|
| ___ Seizures | ___ High fever | ___Measles | ___Mumps |
| ___Chicken pox | ___Whooping cough | ___Tonsillitis | ___Encephalitis |
| ___Asthma | ___Meningitis | ___Croup | ___Heart trouble |
| ___Pneumonia | ___Chronic colds | ___Thyroid | ___Sinusitis |

Please explain checked items here: _____
_____

Are immunizations current? _____ Current general health: _____

Has your child had:
Ear infection?_____
Allergies?_____
Any other serious or recurrent illnesses?_____
Any operations?_____
Any accidents?_____
Any medications? (Past)_____(Current)_____
Vision problems?_____Treatment:_____
Hearing difficulties?_____Treatment:_____
Dental problems?_____Treatment:_____
Other medical History:_____
_____

**Developmental History**
*Age when child:*

Sat up alone_____ crawled_____ stood_____ walked_____ held bottle_____

Fed self_____ used utensils_____

Is the child able to use? Sippy cup_____ Open cup_____ straw_____
Is the child able to take off? Shoes_____ socks_____ pants_____ pullover _____
Is the child able to put on? Shoes_____ socks_____ pants_____ pullover_____
Is the child able to open? Zippers_____ buttons_____ snaps_____
Is the child able to close?Zippers_____Buttons_____ snaps_____
Is the child able to tie shoes?_____
Any difficulty? (Y/N) Swallowing:_____ Chewing:_____ Drinking:_____
Drooling:_____ Food allergies/ Special diet:_____
Attention span for self- directed activities:_____
Attention span for adult-directed activities:_____
Eating and sleeping patterns:_____
_____

**School History**

School Name:_____ Teacher Name:_____
Address:_____
Phone number:_____ Frequency:_____
Receiving special services at school:_____

**Sensory History**

Does your child tolerate touch input? (Y/N) Hair cut_____ Nails cut_____
Being held_____ Shampoo____Bathing_____ Tags in clothing_____
Walking on grass/sand_____ Mess on hands_____ Play doh_____ Finger paint_____
If No explain:_____
_____

Does your child tolerate movement input? (Y/N) Swings_____ Slide_____ Rides_____
If No explain:_____
_____

Does your child tolerate auditory input? (Y/N) Vacuum cleaner_____ Siren_____
Lawn equipment_____ Public restroom____
If No, explain: _____
_____

Does your child tolerate visual input? (Y/N) Easily distracted by visual input_____
Move objects or hands in front of eyes_____ Maintain eye contact_____
Pleas explain responses here:_____
_____

**Other**

What do you hope to have happen as a result of this evaluation?_____
_____
Does the report need to be sent to specific agencies?_____ Where?_____
_____
Anything else you would like us to know?_____
_____
_____
_____
_____
_____
_____