



## NEW PATIENT INTAKE INFORMATION

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Clinic Name: \_\_\_\_\_  
Parent/Caregiver Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Parent/Caregiver Email: \_\_\_\_\_  
Parent/Caregiver Work Phone: Mom: \_\_\_\_\_ Dad: \_\_\_\_\_  
Parent/Caregiver Cell Phone: Mom: \_\_\_\_\_ Dad: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Contact Number: \_\_\_\_\_  
Reason for Visit: \_\_\_\_\_  
Caregiver Goals/Concerns: \_\_\_\_\_  
\_\_\_\_\_

### I. MEDICAL HISTORY

1. Was your child born full term? Y N If no, how early? \_\_\_\_\_
2. Were there complications during pregnancy/delivery/labor? Please describe: \_\_\_\_\_  
\_\_\_\_\_
3. Does your child take any medications? Y N  
Please list the medications: \_\_\_\_\_
4. Does your child have any problems with their eyes/vision? Y N  
Please explain: \_\_\_\_\_
5. Does your child have any problems with their ears/hearing? Y N  
Please explain: \_\_\_\_\_
6. Please describe any significant medical history or additional diagnoses: \_\_\_\_\_  
\_\_\_\_\_

### II. FAMILY/SOCIAL HISTORY

1. Who lives in the home? (Please give ages of siblings) \_\_\_\_\_  
\_\_\_\_\_
2. Does your child attend school or daycare? Y N  
If so, name of school: \_\_\_\_\_  
Are they receiving therapy at school/daycare? \_\_\_\_\_
3. Is your child currently receiving therapy at another location? Y N  
If so, name of clinic: \_\_\_\_\_

### III. DEVELOPMENTAL HISTORY

1. Please list the approximate age your child achieved the following developmental milestones:  
Sat alone: \_\_\_\_\_ Crawled: \_\_\_\_\_ Hand preference: \_\_\_\_\_ Rolling: \_\_\_\_\_

Walked: \_\_\_\_\_ Toilet Trained: \_\_\_\_\_ Dressed themselves: \_\_\_\_\_

Fed themselves: \_\_\_\_\_

2. Does your child eat by mouth? Y N

3. Is your child on a restricted diet? Y N

If so, please specify: \_\_\_\_\_

4. Speech-Language Development (check all that apply)

A. Did/does your child:

\_\_\_\_ Coo, babble

\_\_\_\_ Imitate sounds, words, phrases

\_\_\_\_ Imitate gestures

\_\_\_\_ Understand what you are saying

\_\_\_\_ Retrieve/point to common objects upon request

\_\_\_\_ Follow simple directions

\_\_\_\_ Respond appropriately to yes/no questions

What method of communication does your child use? \_\_\_\_\_

5. Gross Motor Development (check all that apply)

A. Did/does your child:

\_\_\_\_ Lift head while on stomach

\_\_\_\_ bear weight on legs

\_\_\_\_ bear weight on arms

\_\_\_\_ Roll over

\_\_\_\_ stand holding on

\_\_\_\_ stand alone

\_\_\_\_ Throw a ball

\_\_\_\_ run

\_\_\_\_ walk up steps

\_\_\_\_ Jump

6. Fine Motor Development (check all that apply)

A. Did/does your child:

\_\_\_\_ Hold objects in hand

\_\_\_\_ reach for objects

\_\_\_\_ clap hands

\_\_\_\_ Draw

\_\_\_\_ pick up small objects

\_\_\_\_ manipulate fasteners

7. Sensory (check all that apply)

A. Did/does your child:

\_\_\_\_ Have trouble falling asleep

\_\_\_\_ avoid being touched

\_\_\_\_ engage in self-stimulating behaviors

\_\_\_\_ hear things most people tune out

\_\_\_\_ react negatively to "normal" noises

\_\_\_\_ refuse to wear certain clothing

\_\_\_\_ fall frequently

\_\_\_\_ is always in motion

\_\_\_\_ dislike certain temperatures

\_\_\_\_ dislike certain textures

#### IV. ADDITIONAL INFORMATION

1. Does your child use any medical equipment currently? (Ex: communication device, wheelchair, etc...) \_\_\_\_\_

2. What are your child's likes? \_\_\_\_\_

3. What are your child's dislikes? \_\_\_\_\_

4. Does your child have any behavioral difficulties, for example, biting, hitting? Y N

If so, please specify: \_\_\_\_\_

5. What method of discipline is used at home, for example "time out"? \_\_\_\_\_

\_\_\_\_\_  
Parent/Caregiver Signature

\_\_\_\_\_  
Date: