New patient information

Patient Name:

_____

First Middle Last

Date of birth: _____ Gender: _____

Services Seeking:

☐ Speech & Language ☐ Occupational Therapy ☐ Physical Therapy

What are your primary concerns for your child?

_____

Primary Language spoken at home? If there is a secondary, please list as well.

_____

Parent/Guardian 1:

First and Last Name: _____

Parent/Guardian 1 D.O.B: _____

Relationship to child:

☐ Mother ☐ Father ☐ Step parent ☐ Legal Guardian ☐ Grandparent

Parent 1:

_____

Street Address City State Zip code

Parent/Guardian 1 Social Security # (REQUIRED!!): _____

Parent/Guardian 1 Phone Number: _____

Email: _____

Parent/Guardian 1 highest level of education & current employment:

_____

Parent/Guardian 2:

First and Last Name: _____

Parent/Guardian 2 D.O.B: _____

Relationship to child:

☐ Mother ☐ Father ☐ Step parent ☐ Legal Guardian ☐ Grandparent

Parent/Guardian 2:

_____

Street Address City State Zip code

Parent/Guardian 2 Social Security # (REQUIRED!!): _____

Parent/Guardian 2 Phone Number: _____

Email: _____

Parent/Guardian 2 highest level of education & current employment:

_____

Physician Information

Primary Care Physician's Name: _____

Primary Care Physician Practice: _____

Primary Care Physician's Phone Number: _____

Insurance Information

Medical Insurance Provider:

_____

Member ID:

_____

Family History

Are there any cultural or religious beliefs you would like us to be aware of?

_____

Child lives with (Select all that apply):

☐ Both biological parents ☐ Parent & Stepparent ☐ One biological parent ☐ Grandparent

☐ Foster Parents ☐ Adoptive parents ☐ Other

Does anyone in the family have a history of Speech, Language, Hearing, Balance, Reading, or Mobility problems? If yes, please explain.._____

_____

Prenatal, Birth & Neonatal History

Were there any problems during pregnancy? If yes, please describe:_____

_____

Child's Birth Weight (___ lbs. ___oz.):

Delivery: Vaginal or C-section

Was your child born prematurely? If yes, please answer the next question as well.

_____

Child's gestational age (i.e. 34 weeks): _____

Describe any difficulties at the time of birth: _____

Was there a prolonged hospital stay after birth? If yes, please describe WHY and HOW LONG. _____

What feeding method was used after birth? _____

Were there any feeding difficulties? If yes, please describe. _____

Developmental Milestones

Please indicate in **months or years** the approximate age, (or N/A if not age appropriate at this time) that your child achieved the following Milestones. If you are unable to recall the approximate age that your child achieved a milestone, please indicate whether or not you feel it was "On time" or "Late/Delayed". If there are any additional concerns regarding these milestones, please note them.

Skill	Age
Fed self	
Dressed self	
Toilet trained	
Tie shoes	
First words	
Combined words	
Grasp crayon/pencil	
Rolled over	
Sat without support	
Crawled	
Stood	
Walked	

Medical History

Please list any medical diagnoses your child has along with the date of the diagnosis (e.g. ADHD, OCD, Seizures, Asthma, Autism):

_____

Please list any medication your child takes regularly. _____

_____

Does your child have any allergies (food, latex, etc.) If yes, please list: _____

_____

Has your child ever had prolonged problems with (Select all that apply): Thumb sucking, pacifier usage, or drooling?

☐ Yes, history of it ☐ Yes, Current problem ☐ Not at all

When was your child's most recent hearing test/screening? _____

Results of most recent hearing test: **Pass or Fail**

Does your child currently have a known hearing impairment? If yes, what is the severity? _____

My child has had several ear infections. **Yes or No**

My child has had at least one ear infection lasting more than 3 months. **Yes or No**

I suspect my child has a hearing problem. **Yes or No**

My child has had tubes in his/her ears? **Yes or No**

When were tubes put in your child's ears? _____

Does your child wear hearing aids? If yes, what type, and for how long? _____

When was your child's most recent vision test/screening? _____

Results of most recent vision test: pass or fail

Does your child require the use of glasses/corrective lenses? _____

Please list any medical precautions (Fall risks, Seizures, etc.): _____
_____

Does your child require the use of any special equipment (e.g. Wheelchair, Leg braces)? If yes, please specify. _____

Please list any surgical history along with the date of surgery (e.g. Tonsillectomy, Adenoidectomy, etc). _____
_____

If you listed anything in the above question, were there any surgical complications?
_____

Current or Previous treatments

Has your child received any type of therapy? If yes, please explain what type of therapy, what facility, and duration of therapy. _____
_____

School Information

*Note: If your child does **not** go to school, please just answer question one.

If your child does NOT attend a school/preschool and stays home, who does he/she stay home with? _____

Child's school/preschool/daycare: _____

Current grade: _____

Type of classroom: _____

Does your child currently have an Individualized Education Plan (IEP)? **Yes or No**

Does your child receive Speech/Language, Occupational, or Physical Therapy services at school? _____

Has your child ever repeated a grade? If so, what grade? _____

Has your child ever been suspended, expelled, or had significant disciplinary consequences for negative behavior? If yes, please explain. _____
_____

What are your child's academic strengths? _____

List any areas in which your child is struggling: _____

Have academic tutoring services been sought? If yes, please explain which subject(s), who the provider was, and for how long? _____
_____

Communication

How does your child primarily communicate with you/others? (Select all that apply)

☐ Body language (Point, pull, etc.) ☐ 2-4 word phrases ☐ Sounds (Vowels, grunting)

☐ Sentences of 4+ words ☐ Single words ☐ Sign Language

☐ Alternative Communication Device

What percentage of your child's speech do you understand? _____

Does your child.....

Understand most of what people say? **Yes or No**

Consistently respond correctly to "Yes" and "No" questions? **Yes or No**

Often repeat the last thing that you said or engage in excessive repetition of words/sentences heard previously? **Yes or No**

Appropriately label objects in his/her environment? **Yes or No**

Appear to read body language (including facial expressions) appropriately for his/her age? **Yes or No**

Consistently follow directions? (For younger children, do they consistently retrieve or point to common objects- i.e ball, shoe, cup, etc. - upon request? **Yes or No**

Consistently respond correctly to "Who", "What", "When", "Where, "Why", questions? **Yes or No**

Participate in conversations appropriately (i.e. remaining on topic, without interrupting)? **Yes or No**

Have there been any recent changes in your child's communication? If yes, please explain. **Yes or No** _____

Behavior

Do you have concerns regarding your child's behavior? (i.e Attention, Tantrums, Social skills, etc.) If yes, please explain. _____
_____
_____

Feeding

Do you have concerns regarding your child's feeding skills or nutritional intake? If yes, please explain. _____

Does your child often choke on or have difficulty swallowing liquids or solid foods? If yes, please explain below. _____

Does your child drool? **Yes or No**

Activities of Daily Living

Please indicate how your child completes the following tasks.

Task	"Independent, more than 50% help"
Dress/undress self	
Go to bed/Sleep appropriately	
Brush teeth	
Wash/Dry hands	
Bathe in tub or shower	
Drink from an age-appropriate cup (i.e. Bottle, Sippy cup, Cup w/ straw)	
Tie shoes and manipulate fasteners (i.e. buttons, zippers, buckles)	
Sleep through night	
Use the toilet	

Does your child fall/trip frequently? **Yes or No**

What is your child's preferred hand for writing? **Right or Left**

Do you have any additional comments or concerns that were not mentioned in any above questions? _____
_____
_____

_____

Signature of responsible party/ completing intake form/ date completed

Eagles Nest Pediatric Therapy

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