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Intake Information:

The information requested on this form will be used only for purposes of assessing and/or treating your child. Please disregard sections that are not applicable.

Child's Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (_____) _____ Cell Phone: _____ Email: _____
Parent(s)/Guardian(s) Names: _____
Siblings' Names & Ages:

_____ _____ _____ _____
_____ _____ _____ _____

Insurance:_____ ID/Member#_____ Group #_____
Insured: _____ Insured's DOB:_____

Pediatrician and/or Family Physician: _____ Other Physician(s):_____
School/Parent-Infant Program: _____
Referred By: _____
Please describe your concern(s) about your child and what you hope to learn from this evaluation:

_____
_____
_____
_____

Prenatal and Birth History:

Were there complications or risk factors during the pregnancy? Yes____ No____
If "yes," please explain: _____
Length of pregnancy: _____ Duration of Labor (hours): _____
Type of delivery: Vaginal_____ Cesarean_____ induced_____ interrupted_____
Please describe special circumstances: _____
_____
Birth weight: _____lbs. _____ oz. APGAR scores (if known): _____

Child's condition at birth: _____

	M.D./Therapist	Date(s)	Results/Recommendation
Neurology			
Hearing			
Vision			
ENT			
Orthopedic			
Speech/Language			
Occupational Therapy			
Physical Therapy			
Other (cognitive/psychology)			

Good Color? _____ Breathing easily?_____

Any sucking or swallowing difficulty? Yes: _____ Please describe: _____

How soon after birth did you see your infant? _____

Please describe any medical attention (mother or child) required: _____

If your child was in the NICU, length of stay there (days):_____

Other Evaluations:

Please indicate below any evaluations and/or treatment received by your child.

Developmental History:

Please feel free to describe your child/child's interests, activities, and/or sports: _____

_____

_____

_____

Describe your child's personality: _____

_____

At what age could your child do the following:

Hold up head alone: _____ Sit alone: _____ Crawl/creep: _____ Walk unaided: _____

Did you child ever have any motor coordination difficulties such as confusion in regard to left or right-handedness, frequent falling, awkwardness? If yes, explain:

_____

_____

Demonstrate toilet training (bowel? Bladder?): _____

Feeding:

How long does it take your child to eat one meal? _____

Does your child have any particular food preferences? _____

Describe any eating habits or food texture issues: _____

Sleeping

How many hours does your child sleep per night? ___

Does your child typically wake up at night? Yes___ No___ If yes, how many times? _____

Does your child take daytime nap(s)? Yes__ No__ If "yes:" How many_____ Length_____ Current nap times: _____

Please describe any sleeping issues: _____

_____

Speech and Language

During the first year, other than crying, would you describe your child as:

_____ a silent baby _____ a very quiet baby _____ a vocal baby _____ an irritable baby

Please describe your child's early vocalizations (what kinds of sounds? Babbling?) _____

_____

When did your child first speak an understandable word? _____ Put two words together? _____

What type of communication does your child understand (commands, words, simple conversation, pointing)? _____

_____

_____

How does your child typically express wants and needs? _____

_____

Has your child's communication stopped/decreased or otherwise changed significantly at any time? Yes__ No __Please describe:

_____

How easily can you understand your child's speech? _____

_____

Describe your child's play skills. Do you find those play skills to be age appropriate? _____

_____

Has your child been referred or enrolled in speech/language therapy? If yes, please indicate goals: _____

_____

Health and Medical History

Describe your child's general health: _____

_____

_____ Present weight: _____ lbs. Height _____ft. ____ins.

Describe Illnesses:

	Age(s)	Severity/Frequency	Medications/Treatment
Ear Infections			
High Fevers			
Head Injury			
Seizures			
Hospitalizations			
Asthma			
Other			

Does your child have any known allergies? _____ Is your child a "mouth breather"? _____
Immunizations, Age & Reactions: _____
Does your child have any medical diagnoses? _____
Child's immediate family, mother/father's families—please describe all histories of neurological, hearing, speech/language, or hereditary diagnoses: _____

Educational History

Child currently attends the following early intervention/parent-infant programs: _____
Child has attended the following early intervention/parent-infant programs: _____
Name, Grade, and Address of current preschool, grammar school and/or any other programs attended (including tutoring):
_____
Has your child been held back? If yes, which grade: _____
Has school reported current problems with (describe those that apply):

Reading	Describe:
Spelling	Describe:
Writing	Describe:
Math	Describe:
Social Adjustment	Describe:
Attention Span	Describe:
Following Directions	Describe:

What is your child's current attitude toward school? _____
Are you currently working with any other professionals regarding your child? _____
_____

Signature: _____ Date: _____
Relationship to child: _____