



Physical Therapy & Sports Medicine Center

Pediatric Intake Form

Name: _____ DOB: _____

As you answer the following questions, please think of the various stages of your child's development, considering any behavior which comes to mind:

- Reason for OT referral: _____

- Parent's concerns are: _____

- Other precautions or allergies? _____

- Describe your child's vision: _____

- Describe your child's hearing: _____

- Were there times when your child's behavior was difficult to cope with in the family unit? (Please explain)

The following questions are posed to help in compiling a more complete picture of your child from early infancy to present developmental stage. Some of the questions may refer to children who are older than your own.

Check the choice which applies: Yes or No. (Please add important narrative information in the comments section or on the back).

Mother's Health during Pregnancy	Yes	No	Comments
1. Have any infections/illnesses during pregnancy?			
2. Have any complications during delivery and/or labor?			
3. If premature, how early?			
4. What was the child's birth weight?			
5. Apgar Scores? ➤ 1 minute? ➤ 5 minutes?			



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Child's Health at Birth	Yes	No	Comments
1. Was child full term?			
2. Did child have any birth injuries?			
3. Did child require a fetal monitor?			
4. Did child have insufficient oxygen?			
5. Did child require ICU hospitalization?			

A. Prematurity? _____

B. Respiratory problems? _____

C. Need respirator? How long? _____

D. Heart defect? _____

E. Jaundiced? _____

F. History Seizures? _____

G. Protocol for Seizures? _____

H. Have infection at birth? _____

I. Have surgery as newborn? _____

J. Have feeding problems as newborn? _____

Developmental Milestones

1. Were feeding and sleeping patterns easily established? Yes or No. If no, Explain.

2. When did your child consistently sleep through the night? _____



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3. Fussy baby past age of 6 months? Yes or No. If yes, any reason identified?

4. Indicate child's age for achieving the skill. If uncertain, indicate early, late, or typical:

Independent sitting _____ Hands/knees crawling _____ Walking _____ First words _____ Sentences _____

Toilet trained _____ Day night _____

5. Do you think any part of your child's development is slower than average? If yes, explain:

6. Current areas of concern (please mark all that apply): _____ Gross Motor Development _____ Fine Motor Development
_____ Sleeping _____ Language Development _____ Social Skills _____ Eating _____ Play Skills _____ Temperament
_____ Frustrations (list): _____ Fears (list): _____ Independent living skills Other:

7. When did you first notice your child's difficulties and how were they apparent to you?

8. Is there a family history of similar difficulties? If so, who, and what are the difficulties?

9. Please list any previous medical and/or diagnostic tests or evaluations (i.e. neurological, genetic testing, educational, speech/language, developmental, other) and their results. If possible, please attach copies of reports.

Significant test results: _____

Any diagnosis given: _____



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10. Please check if your child has received services from any of the following:

____ Occupational Therapy ____ Tutoring ____ Physical Therapy ____ Psychological Counseling ____ Speech Therapy ____ Special Education

If so, when? Where? (private or public school), and for how long?

Are these services ongoing? _____

Medical and Behavioral History

Please indicate all that are applicable and ages(s): ____ High fevers ____ Meningitis ____ Ear infections / tubes ____ Chicken pox ____ Whooping cough ____ Heart trouble ____ Mumps ____ Scarlet fever ____ Excessive vomiting ____ Allergies ____ Seizures ____ Lung / bronchial difficulties ____ Epilepsy ____ Diabetes ____ Surgery / hospitalization

Other significant accident, injury, or illness? _____

Please specify significant allergies or food restrictions:

Physical or medical precautions or activity restrictions (i.e. due to heart problems, asthma, seizures, Physical limitations, etc.):

Is your child currently on any medication? No ____ Yes ____

Purpose: _____

Names of medication: _____

Dosage: _____

Side effects: _____

What are your child's most preferred activities/ favorite toys? (Indoors and Outdoors)

Indoors: _____



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Outdoors: _____

What are your child's least favorite activities?

Indoors: _____

Outdoors: _____

When is your child most calm or happy? _____

When does your child become most frustrated? _____ Does your child use a transitional object or security toy? (i.e. bear, blanket, and pacifier) _____

Does your child tend to have difficulty learning new motor tasks/games? _____

Does your child resist participating in fine or gross motor tasks? Please explain:

Does your child have any recently acquired skills? _____

Please check the following items that best describe your child:

1. Visual

____ Wears glasses

____ Has a diagnosed visual problem (describe): _____

____ Has difficulty finding / seeing things (i.e. shoes in the closet, toy in a toy basket)

2. Auditory and Language

____ Has a suspected or diagnosed hearing loss

____ Limited or absence of gesturing to assist communication

____ Excessive talking interferes with listening

3. Nonverbal: Do they have a form of communication? List/circle the form of communication system (PECS, Sign Language, gestures used, etc.): If language is not strong, describe the vocalizations your child uses:

____ Oral-Motor and Respiratory Control

____ Displays poor lip control / lip closure for eating, drinking, using utensils

____ Has limited skills with blow toys, whistles, bubbles



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Demonstrates poor saliva control (drools)

Chokes easily on liquids or solids, please specify: _____

Overstuffs mouth with food

Clenches jaw or grinds teeth

Holds breath frequently

Breathes with mouth open / often has mouth open

Noisy breathing / snores

4. Self-care / Regulation of Body Function

Is your child able to complete these tasks independently; please circle (Y)es / (N)o

Y/N Toileting – bowel/ bladder control

Y/N Undresses

Y/N Dresses

Y/N Snaps / Unsnaps

Y/N Buttons

Y/N Zippers pull / engage/ disengage

Y/N Velcro on / off

Y/N Socks on / off

Y/N Self-feeding (finger foods)

Y/N Uses eating utensils

Y/N Uses open cup

Y/N Sippy cup

Y/N Uses a straw



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If your child has difficulty with controlling bowel and / or bladder (day or night or both), please explain:

Additional comments: Please provide any other information that you would like to share about your child (such as your goal of therapy).
