# 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?<br>➢ 1 minute?<br>➢ 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).

_____
_____
_____

# Physical Therapy & Sports Medicine Center

## PATIENT MEDICAL HISTORY

Patient's Name_____ Date of Birth _____/_____/____ Age: _____

Date of Injury or accident___/___/____ Height: _____ Weight: _____

Have you had surgery for this injury? YES NO (If yes, Number of Surgeries____)

Are you currently taking any Prescription or Non- Prescription Medication? YES NO

If yes, fill out the attached Medication List.

Have you had any of the following Medical or Rehabilitation services for this injury YES NO

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Chiropractor | ____ | ____ | Occupacional Therapy | _____ | _____ |
| EMG/NVC | ____ | ____ | Orthopedic | _____ | _____ |
| Massage Therapy | ____ | ____ | Physical Therapy | _____ | _____ |
| Myelogram | ____ | ____ | Podiatrist | _____ | _____ |
| ER CARE | ____ | ____ | X Rays | _____ | _____ |
| CT SCAN | ____ | ____ | MRI | _____ | _____ |
| Gen Prac. | ____ | ____ | | | |
| Neurologist | ____ | ____ | | | |

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Do you now or have you ever had any of the Following?-

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Asthma, Bronchitis, or emphysema | _____ | _____ | Severe or Frequent Headaches | ____ | _____ |
| Shortness of Breath/Chest Pain | _____ | _____ | Vision or Hearing Dificulties | ____ | _____ |
| Coronary Heart Disease or Angina | _____ | _____ | Numbness or Tingling | ____ | _____ |
| Do you have a Pacemaker? | _____ | _____ | Dizziness or Fainting | ____ | _____ |
| High Blood Pressure | _____ | _____ | Hernia | _____ | _____ |
| Heart Attack/Surgery | _____ | _____ | Blood Clot/Emboli | _____ | _____ |
| Stroke/ TIA | _____ | _____ | Veracose Veins | _____ | _____ |
| Bowel or Bladder Problems | _____ | _____ | Allergies | _____ | _____ |
| Epilepsy/Seizures | _____ | _____ | Pins or Metal Implants | _____ | _____ |
| Thyroid Trouble/Goiter | _____ | _____ | Joint Replacement | _____ | _____ |
| Anemia | _____ | _____ | Diabetes | _____ | _____ |
| Infectious Disease | _____ | _____ | Cancer or Chemotherapy | _____ | _____ |
| Emotional/Psychological Problems | _____ | _____ | Osteoporosis | _____ | _____ |
| Arthritis/Swollen Joints | _____ | _____ | Are you Pregnant? | _____ | _____ |
| Gout | _____ | _____ | Do you Smoke? | _____ | _____ |
| Difficulty or unable to sleep | _____ | _____ | Elbow/Hand/Shoulder Surgery | _____ | _____ |
| Leg/ankle/knee/foot Surgery | _____ | _____ | Weakness | _____ | _____ |
| Back/Neck/Surgery | _____ | _____ | | | |
| Have you had any falls in the last year? | _____ | _____ | | | |

Are you aware of your Diagnosis? YES NO

Based on your awareness, what are your expectations/goals while in this program?

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SIGNATURE: _____ DATE: _____/_____/_____

# Physical Therapy & Sports Medicine Center

Draw the Location of your pain on the body outlines and circle the pain face that applies:

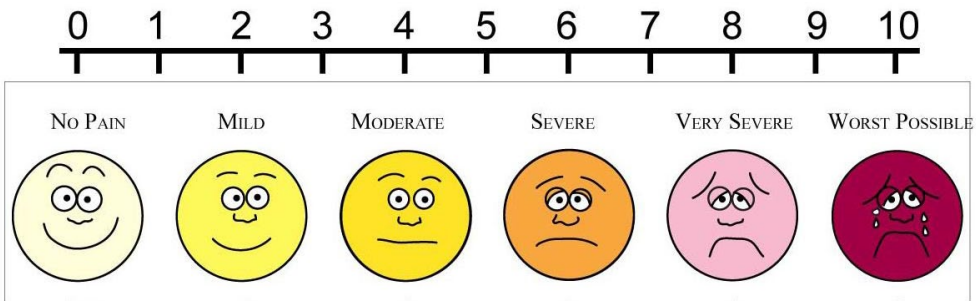
| Pain | Burning | Numbness | Pins & Needles | Stabbing | Other |
|---|---|---|---|---|---|
| ^^^^^^ | * * * * | ∞∞∞∞ | ..... | /////// | XXX |

**FRONT** **BACK**

SIGNATURE: _____ DATE: _____/_____/_____

**RIGHT** **LEFT**

**LEFT** **RIGHT**




SIGNATURE: _____ DATE: _____/_____/_____

# Medication List

Name: _____ Date: _____

| Medication | Dosage | Frequency | Route of Administration |
|---|---|---|---|
| | | | |
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