IN-SYNC PEDIATRIC THERAPY CENTER

HISTORY INTAKE FORM

(Please complete and return)

Please answer the questions to the best of your ability and in as much detail as possible. Please add any information that you feel is important but is not covered on this form.

Patient Name:_____ DOB:_____

Diagnosis:_____ Primary Phone:_____

Mother's Name:_____ Work Phone:_____

Father's Name:_____ Work Phone:_____

Guardian's Name:_____ Message #:_____

Siblings Names and Ages:_____

_____

Who is the patient's primary care giver?_____

Has the patient received any previous therapy? _____Yes _____No If Yes:

When: _____ How Long:_____

Where:_____ Date of last evaluation:_____

Does the patient attend daycare, preschool, or school: _____Yes _____No

If Yes, Where:_____

What languages are used in the home:_____

HEALTH OF MOTHER DURING PREGNANCY

1. Any illnesses or accidents: _____Yes _____No If yes, please explain:_____

   _____

   _____
2. Any medications: _____Yes _____No If yes, what:_____

   _____
3. Pregnancy:_____months
4. Labor:_____hours
5. Baby was delivered: _____Cesarean _____Vaginal
6. Baby's birth weight: _____lbs. _____ounces
7. Expected due date:_____
8. Any difficulty at time of birth: _____Yes _____No If yes, please explain:_____

   _____

   _____

HEALTH OF PATIENT

1. Serious illness or deformities: _____Yes _____No If yes, please explain: _____

2. Serious accidents or injuries: _____Yes _____No If yes, please explain: _____

3. Any surgeries: _____Yes _____No If yes, please explain: _____

4. History of high fever: _____Yes _____No If yes, please explain: _____

5. History of seizures: _____Yes _____No If yes, please explain: _____

6. Allergies: _____Yes _____No If yes, please explain: _____

7. Is the patient taking any medications now: _____Yes _____No If yes, please explain:

8. Eye problems: _____Yes _____No If yes, please explain: _____

9. Was the patient bottle fed: _____Yes _____No
10. Does the patient take a bottle at this time: _____Yes _____No
11. Does the patient have frequent colds, sore throats, or earaches: _____Yes _____No
12. Has the patient's tonsils and/or adenoids been removed: _____Yes _____No

DEVELOPMENTAL HISTORY OF PATIENT (please circle yes or no and give age)

1. Holds head up: Y N Age: _____
2. Rolls over: Y N Age: _____
3. Sits alone: Y N Age: _____
4. Crawls: Y N Age: _____
5. Pulls to stand: Y N Age: _____
6. Stands alone: Y N Age: _____
7. Walks alone: Y N Age: _____
8. Run: Y N Age: _____
9. Grasps toys: Y N Age: _____
10. Puts things hand-to-hand: Y N Age: _____
11. Feeds self with fingers: Y N Age: _____
12. Feeds self with spoon: Y N Age: _____
13. Scribbles: Y N Age: _____

Describe any positions or movements that the patient likes or dislikes:_____

_____

Describe any specific concerns you have about the patient or his/her development:_____

_____

_____

SPEECH HISTORY:

1. Does the patient have a speech impairment: _____Yes _____No
2. Does the patient have a hearing impairment: _____Yes _____No
3. Is the patient responsive to sounds or voice: _____Yes _____No
4. When did the patient begin to use single words: _____months
5. When did the patient begin to use sentences: _____months
6. Does the patient speak in: _____words _____phrases _____complete sentences
7. When were you first concerned about a speech or hearing impairment:_____

   _____
8. Can the patient be understood by parent/guardian: _____Yes _____No
9. Do other family members have a speech or hearing impairment: _____Yes _____No

   If yes, who?_____
10. Has the patient ever had more words than he/she has now: _____Yes _____No
11. Has the patient's hearing ever been tested: _____Yes _____No

    If yes, when?_____Pass? _____Yes _____No

Are there any problems with the following:

Tongue	_____	Throat	_____	Drooling	_____
Jaws	_____	Teeth	_____	Writing	_____
Palate	_____	Chewing	_____	Reading	_____
Nasal Passages	_____	Swallowing	_____		

Can the patient do the following without help:

Dress/Undress:	_____Yes	_____No	Bathe:	_____Yes	_____No
Clothes fasteners:	_____Yes	_____No	Brush teeth:	_____Yes	_____No
Go to bathroom:	_____Yes	_____No	Feed self:	_____Yes	_____No

OTHER IMPORTANT INFORMATION/CONCERNS:

What specific skills or areas are you concerned with regarding school readiness?_____

_____

Does the patient have difficulty adapting to change: _____Yes _____No If yes, please explain:

What areas do you consider as strengths for the patient:

Does the patient need to be reminded or redirected to complete tasks: _____Yes _____No
If yes, please explain:

Does the patient have daily responsibilities or chores at home: _____Yes _____No If yes, please explain:

How long can the patient stay on task:

Can the patient complete a task in a timely manner: _____Yes _____No
Are reminders or time limits required: _____Yes _____No
Can the patient express his/her needs adequately: _____Yes _____No
If yes, is it done verbally, by pointing, etc:

What types of activities/interests does the patient like:

Does the patient avoid any activities: _____Yes _____No If yes, please explain:

BEHAVIOR (please circle the statements that describe the patient):

Happy	Nervous	Prefers to play alone	Destructive
Temper tantrums	Sensitive	Nightmares	Stubborn
Cries easily	Thumb sucks	Overactive	Easily managed
Slow learner	Shy	Outgoing	Unusual fears
Jealous	Sad	Demands excessive	Affectionate
Friendly	Attention	Has NO playmates	Plays well with others
Energetic	Likes school	Has playmates	Overly talkative

ADDITIONAL INFORMATION MAY BE ADDED TO THE BACK OF THIS FORM.

Signature Relationship to child Date