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.

Child's Name: _____ Date of Birth: _____

Diagnosis: _____ Primary Phone: _____

Mother's Name: _____ Work Phone: _____

Father's Name: _____ Work Phone: _____

Guardian's Name: _____ Message #: _____

Siblings Names and Ages: _____

_____

Who is your child's primary care giver? _____

Has your child received any previous therapy? ___Yes ___No If yes:

When? _____ How long?_____

Where? _____Date of last eval? _____

Does your child 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: _____

_____

_____

CHILD'S HEALTH

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 your child taking any medications now? ___Yes ___No If yes, please explain: _____

_____

_____

8. Eye problems? ___Yes ___No If yes, please explain: _____
9. Was child bottle fed? ___Yes ___No At this time? ___Yes ___No
10. Is child toilet trained? ___Yes ___No
11. Does your child have frequent colds, sore throats, or earaches? ___Yes ___No
12. Have tonsils and adenoids been removed? ___Yes ___No

Developmental History (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. Runs: 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 your child likes or dislikes: _____

_____

Describe any specific concerns you have about your child or his/her development: _____

_____

_____

SPEECH HISTORY

1. Does your child have a speech problem? ___Yes ___No
2. Does your child have a hearing problem? ___Yes ___No
3. Is your child responsive to sounds or voice? ___Yes ___No

4. When did your child begin to use single words? _____ months
5. When did your child begin to use sentences? _____ months
6. Does child speak in _____words ____phrases ____complete sentences?
7. When were you first concerned about a speech or hearing problem? _____
8. Can child be understood by parents? ___Yes ___No
   By other children? ___Yes ___No
   By strangers? ___Yes ___No
9. Do other family members have a speech or hearing problem? ___Yes ___No
   If yes, who? _____
10. Has your child ever had more than he has now? ____Yes ___No
11. Has your child's hearing ever been tested? ___Yes ___No
    If yes, when? _____

Are there any problems with the following?

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

Can your child do the following without help? (circle yes or no)

Dress/undress: *Yes No*	Bathe: *Yes No*	Brush teeth: *Yes No*
Clothes fasteners: *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 your child have difficulty adapting to change? ___Yes ___No If yes, explain: _____

What areas do you consider as strengths for your child? _____

_____

Does your child need to be reminded or redirected to complete tasks? ___Yes ___No If yes, please explain: _____

_____

Does your child have daily responsibilities or chores at home? ___Yes ___No If yes, please explain: _____

_____

How long can your child stay on task? _____

Can your child complete a task in a timely manner? ___Yes ___No

Are reminders or time limits required? ___Yes ___No

Can your child express his/her needs adequately? ___Yes ___No

If yes, is it done verbally, by pointing, etc.? _____

What types of activities/interests does your child like? _____

Does your child avoid any activities? ___Yes ___No If yes, please explain: _____

_____

BEHAVIOR (please circle the statements that describe your child)

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	Energetic	
Likes school	playmates	Overly talkative	

ADDITIONAL INFORMATION CAN BE ADDED TO THE BOTTOM OR BACK OF THIS FORM

_____ _____ _____

Signature Relationship to child Date