CENTRAL FLORIDA PEDIATRIC THERAPY ASSOCIATES

Physical Therapy – Occupational Therapy – Speech Therapy

INTAKE & BACKGROUND QUESTIONNAIRE

Patient Information Today's Date:_____

Child's Name_____ Age_____

Date of Birth_____/_____/_____ Gender _____

Child's Home Address_____

What are your primary concerns for having your child evaluated and treated?

_____

_____

Referring Physician_____

Primary Care Physician_____

Clinic Name_____

Diagnosis_____ Date of Diagnosis_____

Current Medications_____

Allergies_____

Is the child receiving any therapies at this time: Yes No

What and where? _____

_____

FAMILY INFORMATION

Parents/Guardian Names_____

Home Phone_____ Cell Phone_____

Work Phone_____

Parent Email Address_____

Family members in the home_____

Languages spoken in the home_____

Is there any known history of the following in the immediate or extended family?

Autism/PDD	ADHD	Learning Disabilities
Hearing Loss	Stuttering	Speech/Language Delays

PREGNANCY & BIRTH HISTORY

Did mother have any illnesses or complications during pregnancy or delivery? Yes No

Comments _____

Any medications, alcohol or other drug use during pregnancy? Yes No

Comments _____

At how many weeks was the child born_____ Birth Weight_____

Did child require hospital stay or time in NICU? Yes No

Comments _____

Did your child require any medical procedures before, during or after birth? Yes No

Comments _____

Were there any complication with bottle or breast feeding? Yes No

Comments _____

Was your child bottle fed or breast fed and for how long?_____

Did they have any colic or reflux issues? Yes No

Comments _____

MEDICAL HISTORY

Has your child experienced any of the following? *(please check all that apply)*

Cleft Palate/Lip Seizures Frequent ear infections or fluid in the ears
Feeding Tube Gastroesophageal Reflux PE Tubes (if so, when?_____)

Please describe illnesses, medical issues, or hospitalization that your child has had and when.

_____
_____

Has your child seen a specialist, or had other evaluations/testing?_____
_____

Has your child received or is currently receiving other therapies?_____
_____

Are there any other precautions we should know about that are not already described?

_____
_____

DEVELOPMENTAL MILESTONES

Please note when each of the following occurred.

Roll over_____ Sit Up_____
Crawl_____ Was crawling phase brief? Yes No
Walk_____
Drink from a cup_____ Feed Self_____
Toiled Trained_____ What is the frequency of BMs?_____ Constipation or loose bowels? Yes No Stomach aches? Yes No

SELF HELP

Please describe how much assistance does child needs for:

Eating_____
Dressing_____
Toileting_____
Bathing_____
Washing hands & face_____
Brushing teeth & hair_____

EATING & DIET

Is your child a picky eater?	Yes	No	Comment:
Are they on a special diet?	Yes	No	Comment:
Do they have any food allergies or intolerances?	Yes	No	Comment:
Do you feel they get enough to eat and has a balanced diet?	Yes	No	Comment:

Please explain what your child typically eats for meals throughout the day.

Breakfast_____
Lunch_____
Dinner_____

Snacks_____

HEARING & VISION

Has your child's hearing been recently evaluated? Yes No

*If yes, when, by whom and what were the results*_____

_____

Is their vision within normal limits? Yes No

_____

SPEECH & LANGUAGE DEVELOPMENT

Please describe your child's primary mode of communication (gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange)?_____

_____

If your child is talking, please indicate at what age your child began to:

Babble_____ 2-3 word phrases_____ First Words_____

Use language as primary mode of communication:_____

How much of your child's speech do you understand?

25% or less 25-50% 50-75% 75-100%

How much of your child's speech do others understand?

25% or less 25-50% 50-75% 75-100%

Are there specific sounds your child has difficulty saying?_____

Does your child demonstrate frustration when he/she is not understood? Yes No

*If yes, please explain*_____

BEHAVIOR & SOCIAL SKILLS

Follows verbal directions	Yes	No	Comment:
Initiates conversations	Yes	No	Comment:
Makes eye contact when speaking	Yes	No	Comment:
Has safety awareness	Yes	No	Comment:
Is impulsive or a risk taker	Yes	No	Comment:
Displays aggression toward self or others	Yes	No	Comment:
Enjoys roughhouse play	Yes	No	Comment:

Please describe your child's personality_____

_____

What do you feel are your child's strengths?_____

_____

Does your child have tantrums? Yes No If yes, how often?_____

How do you handle discipline issues at home?_____

_____

What are used for motivators or incentives for positive behavior at home or at school?
_____Does child tend to play alone or with others?_____

DAILY ROUTINE

What time does child go to bed on week nights?_____ Weekends?_____
Does child have difficulty falling asleep?_____
Does child wake during the night? Yes No If so, how often?_____
For what reason?_____ Does child tend to wake with difficulty or refreshed?_____
How well does your child handle transitions/changes in routine?_____
_____
What are child's favorite toys/activities?_____ How well does your child organize/keep track of belongings?_____

EDUCATION

Name of School_____ Grade_____
Teacher_____ Weekly schedule:_____
Type of classes Regular Special Education Life Skills Other
Do you have any academic concerns?_____
Is child is happy with school?_____home?_____friends?_____ If your child is not in school, where do they stay during the day?_____

What are your goals/what do you or your child hope to gain from therapy?_____
_____
_____
_____

Thank you for taking the time to complete this form!