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www.redwoodpediatric.com

Intake Form

Thank you for your interest in our clinical services. To help us better serve you, please provide us with the information requested below. Please be assured that this information will be held confidential, and is necessary for the RPTA staff to determine the most appropriate evaluation and therapy services. A copy of our *Notice of Privacy Practices* is also available upon request.

I. General Information

Your Name:

Child's Name: **Date of Birth**:

Parent(s) Names(s):

1. **Phone:** **Email**
2. **Phone:** **Email**

If separated, divorced, or foster, who has legal custody:

Preferred method of contact and best time to reach you:

Name of MD or referral source:

Insurance information:

Do you have a written referral/prescription? **Yes** **No**

What services are you interested in? **Occupational Therapy** **Physical Therapy**

Days available for therapy, and preferred time(s)
Please note we may have a waitlist, and afternoons are the most popular times.

Mon
Tues
Wed
Thurs
Fri
Other comments

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Primary Concerns:
Please describe what brings you to RPTA for an evaluation and when these concerns began.

II. Family History:

Please list who lives with your child

Name	Relationship	Age (of siblings)

Is there a *family history* of the following?:

- Learning Difficulties (reading, math, writing, spelling)
- Speech or Language problem (articulation, stuttering, etc.)
- Developmental Disorder (such as Autism, Asperger's disorder, etc.)
- Psych/Emotional Problems (depression, excessive anxiety, mood swings, OCD, etc.)
- Cognitive Disorder (Intellectual disability, Attention-deficit, etc)
- Addiction

Languages spoken at home:

Please describe afterschool childcare, dual household arrangements or other pertinent living situation:

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III. Child's Social History

Sports or organized extra-curricular classes or activities:

A snapshot of child's personality, strengths, and favorite things/activities:

Educational History:

Name of School: Grade:

Hours/Days Attending:

Does your child have an IEP? **Yes** **No** If yes, please list services:

Therapy History

Has your child received occupational or physical therapy in the past? **Yes** **No**

Has an assessment been done in the past year"? **Yes** **No**

Birth History:

Biological Child Adopted or other

Weeks gestation: Delivery: Vaginal C-Section

Weight at birth: Length at birth: APGAR scores:

Passed newborn hearing screen? **Yes** **No**

Mothers pregnancy

- No complications
- Blackouts
- Falls
- Physical injury
- Excessive bleeding
- Hypertension
- Diabetes
- Emotional stress
- Toxemia
- Alcohol and/or drug use
- Use of tobacco

Child's Delivery

- Normal
- Induced labor
- C-section
- Breech birth
- Unusually long labor (>12 hrs)
- Premature # of weeks
- Overdue # of weeks
- Other problem (specify)

Child's Condition at Birth

- Normal
- Lack of oxygen
- Breathing problem
- Birth injury/defect
- Jaundice
- ICU # of days
- Other problem (specify)

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Explanations:

Was there any weight gain or feeding issues when your child was a baby?

Was your child difficult to console when agitated?

Please describe your child's activity level and sleep patterns as an infant:

Pertinent Medical History

Pediatrician's Name:
Please list other specialists (medical, psychological) working with your child:

Name: specialty:

Name: specialty:

Name: specialty:

Please list your child's diagnosis(s) if applicable:

Please list current medications:

Please list any allergies:

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Please check any that apply to your child (Describe details, dates and/or age of onset):

- Chronic ear infections
- Ear tubes
- Hearing Problems
- Vision Problems
- Wears glasses
- Respiratory Issues
- Cardiac Issues
- Orthopedic issues
- Reflux
- Feeding tube
- Genetic disorder
- Seizures
- Head Injury
- Other
- Other

Developmental History:

Record any previous developmental concerns, hospitalizations, or other events

Infancy/Toddler:

Preschool:

Elementary School:

Current Skills:

Sensory Processing

Does your child display sensitivity to sensory input (e.g. movement, sounds, touch, taste, smell, other?) Please give specific examples.

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Does your child seem to seek or crave certain types of sensory input (e.g. jumping a lot, frequently spinning, often fidgeting with hands, mouthing objects, messy play).

Does your child require more time than other children to process information (respond to your questions, register pain, etc.)

How does your child tolerate group situations (playing with others on playground, working with peers in school, family gatherings)?

How does your child tolerate errands outside the home?

How does child tolerate restaurants or other outings?

Does child hyper focus on certain activities?

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SENSORIMOTOR	N/A	Seldom	Sometimes	Often
Child seems 'floppy' when holding him/her Needs more support than peers to sit upright				
Slouches/slumps in seats				
Prefers to lie on floor to play				
Difficulty initiating or copying movements				
Awkward gait pattern (Floppy, Stiff, on toes, etc) Difficulty coordinating left/right sides				
Clumsy / bumps into objects / trips easily				
Poor strength Seems fearful of movement				
Unusual pencil grip-immature/tight/weak				
Switches hands frequently				
Increased/decreased pressure on writing tools				
Difficulty coordinating left and right hands				

MOTOR PLANNING	N/A	Seldom	Sometimes	Often
Plays with the same toys, or in the same way, difficulty being flexible or creative. Unable to remember sequences of steps for motor tasks from one day to the next				
Difficulty imitating motor tasks from a given demonstration (verbal and visual)				

VISUAL PERCEPTION	N/A	Seldom	Sometimes	Often
Difficulty completing puzzles				
Poor spatial relations/concepts (i.e. big-small, under-over, front-behind)				
Unable to copy from blackboard or loses place				
Reverses letters in writing (over 7 years old)				

Other sensory concerns:

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BEHAVIOR	N/A	Seldom	Sometimes	Often
Becomes easily frustrated				
Impulsive				
Annoys / distracts others frequently				
Verbally / physically aggressive				
Cannot tolerate changes in routine				
Unable to attend to age appropriate tasks				
Prefers to play alone				
Follows your directions				
Inflexibility with change				

Other behavior or social concerns:

Gross Motor Skills **0 =** unable to do task **1=**	*Check one* somewhat can do **2=** performs **0 1 2**	task proficiently Is this a concern?
Rolls		
Sits with no support		
Crawls on hands and knees		
Walks unaided		
Jumps with two feet		
Runs		
Catches a ball with two hands		
Throws a ball with one hand		
Climbs a play structure		
Rides a trike		
Rides a bike		
Stands on one foot		
Walks on a curb, one foot in front of another		
Does jumping jack		
Pumps legs to swing		

Other Gross Motor concerns:

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Fine Motor Skills **0 =** unable to do task **1=** somewhat can do **2=** performs task proficiently	*Check one* **0 1 2**	Is this a concern?
Shows a hand preference left right		
Can pick up a Cheerio between index finger and thumb		
Can feed self with a spoon		
Can use scissors		
Builds with age appropriate sized blocks or Legos		
Strings beads		
Can draw a straight line		
Can copy simple shapes		
Can write legibly for his age		
Can open/close containers		

Other Fine Motor concerns:

Self-Help Skills **0 =** unable to do task **1=** somewhat can do **2=** performs task proficiently	*Check one* **0 1 2**	Is this a concern?
Can undress self		
Can dress self		
Can manage buttons or snaps on clothes		
Orients clothes correctly when dressing		
Ties shoes		
Can unzip and load zipper independently		
Can unbuckle/buckle a belt		
Can feed self with utensils		
Can drink from an open cup		
Can use toilet independently		
Puts away toys		
Completes familiar routines getting ready in the morning		
Completes familiar routines getting ready for bed		
Can use toilet independently		

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Describe any chores or responsibilities that your child has at home:

List any other Self-Help concerns:

Please list 3 goals you would like to see your child achieve in therapy:

1.

2.

3.

Click to save and continue later

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