Bi-County
Speech, Occupational &
Physical Therapy Bilingual Spanish and English

INTAKE INFORMATION

Patient Name: **DOB:**
Date of Appointment:

***Please take some time to fill out the information below. We ask that you return the information digitally, so that we have the information before the evaluation appointment time. Thank you.**

What are your concerns with your child today?

Okay how they talk, mom when they talk with you, do they use their own way of speaking or will they use whole sentences/phrases?

Can you give me an example?

FAMILY BACKGROUND :

- Child lives with:
  Mother__________________________Father_____________________________
  Siblings name and ages: ____________ , ____________, ____________, ______
- Languages spoken in the home: ______________, ________________, ______________
- Discipline: ☐adequate ☐permissive ☐strict ☐inconsistent

DEVELOPMENTAL MILESTONES:

Age: crawled (crawls on all 4's, quadruped) how long did they crawl? When? Did they use quadruped with correct hand and leg placement? _______, walked__________, babbled_________, first words_________

Aversions: ☐touch ___________ ☐smell _____________ ☐ sounds ___________
☐tastes ___________ ☐face washing ☐ teeth brushing
☐food ☐other: if aversive reaction, how do they respond and are they able to self soothe?

Demeanor: ☐ friendly ☐ shy ☐ social
☐ active ☐ emotional

REASON FOR REFERRAL:

☐ Academic concerns
☐ Sensory processing irregularities
☐ Fine/gross motor delay
☐ Social skills delay
☐ Attention deficits
☐ Developmental delay
☐ Behavioral concerns
☐ Speech concerns
☐ Language concerns
☐ Processing of information
☐ Fluency concerns
☐ Voice concerns
☐ Feeding

PRENATAL HEALTH:

Weeks of Gestation: Birth Weight: Length: If preemie, APGAR scores?
Complications: ____________________

MEDICAL HISTORY:

☐ Difficulties hearing ☐ Heart problems ☐ Diabetes ☐ Allergies
☐ Breathing problems ☐ Asthma ☐ Recurrent ear infections
☐ Seizures ☐ GERD (reflux) ☐ Other: ____________________
Has your child been seen by a Neurologist? ☐ YES ☐ NO

MEDICATIONS:

☐ Current medications: ____________________
☐ No medications at this time.

CURRENT FORM (S) OF COMMUNICATION:

☐ Gestures ☐ Physical directing ☐ Vocalizations
☐ Babbling ☐ Jargon ☐ Echolalia
☐ 1- word utterances ☐ Occasional phrases ☐ Augmentative Device
☐ 2-word phrases ☐ Code switching
☐ Sentences ☐ Other: ____________________

Bi-County Speech, Occupational & Physical Therapy Bilingual Spanish and English

VISION

☐ Appears WNL ☐ Visually Impaired ☐ Wears Glasses ☐ Nystagmus
☐ Strabismus ☐ Tracks Horizontally ☐ Tracks Vertically
☐ Smooth/Jerky ☐ Convergence ☐ Other: ___________________

HEARING

☐ Appears WNL ☐ Apparent Hearing Deficits ☐ Wears Hearing Aide(s)
☐ Startles Easily ☐ Sign Language ☐ Auditory Processing
☐ AAC Device: _______________
☐ History of ear infections? If so: How many have they had in a month? On antibiotics/change in antibiotics? Did the infection clear up with medicine, or did it recur?

EDUCATION:

☐ School ☐ Preschool/Daycare ☐ Home

Name of School: ____

- Has your child been evaluated by the school district?
  ____
- Does your child currently have an: ☐ IEP ☐ IFSP ☐ other:_____________________
  - If yes, please bring a copy to the initial evaluation session.
- Does your child currently have a diagnosis? ☐ Yes ☐ No
  - If yes, please list the diagnosis:____

PREVIOUS INTERVENTION:

☐ No history of previous therapy.
☐ Has received:

THERAPIES:

OT ☐ Current (___x/wk) ☐ Previous (___x/wk)
PT ☐ Current (___x/wk) ☐ Previous (___x/wk)
ST ☐ Current (___x/wk) ☐ Previous (___x/wk)
☐ Other :____

FEEDING/ORAL MOTOR:

☐ Breastfeeding with proper latching
☐ Bottlefeeding with adequate suck? When did they finish bottle feeding?
☐ Uses Pacifier
☐ Drinks From: (Bottle/Sippy Cup/Straw Cup/ Regular Cup)
☐ Bites/Chews straw
☐ Uses Utensils to Feed
☐ Tolerates (Variety/Limited) Food Textures:___________________________
☐ Chokes when eating or drinking? Y N How often? ___________
☐ Uses Utensils to Feed

SENSORY CONSIDERATIONS:

☐ Enjoys jumping
☐ Very active
☐ Walks on toes
☐ Enjoys throwing themselves/toys
☐ Biting, themselves or others
☐ Textures? Like sticky/sand (aversive?)

SOCIAL BEHAVIOR OBSERVATION:

☐ Auditory/visually alert and attentive
☐ Age-appropriate attention span
☐ Appropriate attending and responding behaviors
☐ Cooperative
☐ Friendly
☐ Sociable
☐ Interactive
☐ Appropriate use of eye contact
☐ Easily separated from parent (s)
☐ Well-behaved
☐ Restricted affect
☐ Separation anxiety

☐ Auditory/visually alert yet inattentive
☐ Short attention span
☐ Inconsistent attending and responding
☐ Uncooperative
☐ Easily frustrated
☐ Immature
☐ Non-interactive
☐ Poor eye contact
☐ Hyperactive
☐ Distracted
☐ Impulsive
☐ Other

Requires assistance during dressing with:
☐ shirt ☐ pants ☐ socks ☐ shoes ☐ buttons, zippers, snaps ☐ lacing/tying
☐ Other:
☐ Does not requires assistance

Requires assistance during hygiene with:
☐ Washing Hands/Face ☐ Washing Body/Hair ☐ Brushing Teeth
☐ Does not requires assistance

Toileting Status:
☐ Independent/Potty Trained ☐ Training ☐ Wears Diapers
Comments:

Feeding:
☐ Finger feeds ☐ Uses Utensils to Feed (Spoon/Fork/Knife)
☐ Drinks From: (Bottle/Sippy Cup/ Reg. Cup)

GROSS MOTOR:
☐ Independent Mobile ☐ Dependent
Walks with: ☐ Walker ☐ Crutches ☐ Orthotics ☐ Cane ☐ N/A

EQUIPMENT OWNED:
☐ N/A ☐ Wrist Splint (R/L) ☐ Elbow Splint (R/L) ☐ Writing Tool ☐ Feeding Aid
☐ Dressing Aid ☐ Wheel Chair ☐ Stander ☐ Walker ☐ AFOs ☐ Reacher ☐ Other:

I attest that the information in this document is true and accurate.

__________________________________ __________________________
Name of person filling out this form Relation to patient

__________________________________ __________________________
Name of person filling out this form Relation to patient