NEW PATIENT INTAKE FORM **FUNCTION FIRST THERAPY, LLC**

PATIENT DEMOGRAPHICS

Patient Last Name: ______________________ First Name: ______________________

Date of Birth: ______________________ Sex: ☐ Male ☐ Female

Referred By: ______________________ Reason for Referral: ______________________

City: ____________________ State: ________ Zip Code: ______________________

Primary Care Doctor: ______________________ Office Name: ______________________

PARENT/GUARDIAN CONTACT INFORMATION

Name: ______________________ Relationship to Patient: ______________________

Insured? ☐ Yes ☐ No Insurance Provider: ______________________

Policy / ID #: ______________________ Group #: ______________________

Home/Cell Phone: ______________________ Email: ______________________

EMERGENCY CONTACT INFORMATION

Name: ______________________ Relationship to Patient: ______________________

Home/Cell Phone: ______________________ Work Phone: ______________________

HEALTH HISTORY QUESTIONNAIRE

Health Care Providers: ____

Patient Birth Weight: ______________________ What was the type of birth? ☐ Vaginal ☐ Cesarean

If cesarean birth, why? ____

Was the baby born ☐ at term ☐ early ☐ late If early, how many weeks gestation? ______________________

Were there any health issues with the baby right after birth? ☐ yes ☐ no

If yes, please explain: ____

During pregnancy, did mother:

Smoke ☐ Yes ☐ No Drink Alcohol ☐ Yes ☐ No Use Drugs or Medication ☐ Yes ☐ No

If yes, what substance: ______________________ When used: ______________________

Has your child previously had, or currently have, any of the following health conditions:

☐ ADHD ☐ Hearing Impairment ☐ Speech & Language Impairment ☐ Cancer
☐ Seizures ☐ Autism ☐ Developmental Delays ☐ Asthma
☐ Stroke ☐ Diabetes ☐ Vision Difficulties ☐ Heart Problems
☐ Down Syndrome ☐ Spinal Cord Injury ☐ Orthopedic Injuries ☐ Cerebral Palsy
☐ Any other significant health concerns: ______________________________

____

Please list anything that your child is allergic to and their reaction.

Food Allergies & reaction: ______________________________

Medications & reaction: ______________________________

Other: ______________________________

Please list current medications and/or supplements:

Medication/Supplement	Dosage	Frequency Taken	Side Effects	Prescribing M.D.

Is your child currently seeing, or has your child in the past been seen by any of the following services: ☐ OT ☐ PT ☐ SLP

Has your child ever had any academic or psychological testing? If yes, please describe:

____
____
____

Is your child enrolled in daycare and/or school? If yes, please describe:

____
____
____

DEVELOPMENTAL HISTORY

What do you feel your child's strengths are?

____
____
____

What do you feel your child's needs are?

____
____
____

Physical Skills:

At what age did your child first do the following:

Roll: ________________________ Sit: ________________________ Stand: ________________________

Walk: ______________________ Climb Stairs: ________________

Does your child use an adaptive device to ambulate? ☐ Yes ☐ No

If yes, please explain the device: ____

Describe any problems/concerns (coordination, balance, falls, etc.): ______________________________
____

Communication:

Is this related to the reason your child is being seen today? ☐ Yes ☐ No

Check any of the following that describe your child:

☐ Difficulty following directions	☐ Talk too slowly	☐ Talks too fast
☐ Repeats certain sounds/words over & over	☐ Talks too softly	☐ Can't relay information
☐ Using only gestures to communicate	☐ Talks too loudly	☐ Uses a pacifier?

How much of what your child says do you understand? ☐ >5% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do others understand your child? ☐ Yes ☐ No

Describe any other problems/concerns: ____
____

Feeding:

Is this related to the reason your child is being seen today? ☐ Yes ☐ No

At what age did your child first do the following:

Wean from the bottle: ____________ Finger feed: ______________ Take solid food: __________________

Use a spoon/fork: ________________ Drink from a cup: __________ Use a straw: ______________________

Does your child prefer or avoid certain foods or food textures? ☐ Yes ☐ No

If yes, please explain: ____

Describe any problems/concerns: ____________________

____

Self-Care:

Is this related to the reason your child is being seen today? ☐ Yes ☐ No

At what age did your child first do the following:

Wash hands: ________ Undress: ________ Dress: ________

Button: ________ Brush teeth: ________ Comb hair: ________

Tie shoes: ________ Become bladder trained: ________ Become bowel trained: ________

Describe any problems/concerns: ____________________

____

Hearing:

Is this related to the reason your child is being seen today? ☐ Yes ☐ No

Check any of the following that describe your child:

My child has a diagnosed hearing loss: ☐ Yes ☐ No

My child wears a hearing aid: ☐ Yes ☐ No If yes, child wears aid in: ☐ Right Ear ☐ Left Ear

Social Skills:

Does your child separate easily from parents? ☐ Yes ☐ No

If no, please explain: ____________________

Does your child play alone? ☐ Yes ☐ No If yes, for how long at a time? ________

Does your child play with other children: ☐ Yes ☐ No

If yes, doing what and for how long at a time? ____________________

What are your child's favorite toys and/or play activities? ____________________

____

Parent/Guardian Signature: ____________________ Date: ________

Therapist Signature: ____________________ Date: ________