Email: admin@leapsandbounds.org.au
ABN: 34 652 857 148

Intake Form

This form can be completed by a child's family, a health professional, or a teacher/educator (with consent of the child's family).

Basic Information

Full name: ______________________________________

Age: ____ Date of Birth: __/__/__

Preferred Pronoun: ☐ he/him ☐ she/her ☐ they/them

Main spoken language: ____________________ Do you require an interpreter Yes ☐ No ☐

Occupation/School: ______________________________________

Grade: ___

Currently accessing additional support at school: Yes ☐ No ☐

Do you or your child identify as: ☐ N/A ☐ First Nations ☐ Aboriginal ☐ Torres Strait Islander

Do you require any accommodations to make your visit to the clinic more comfortable? Yes ☐ No ☐

If yes, please specify: ____

Parent/Carer Information

Name: ___________________________ Name: ___________________________

Relation to Child: __________________ Relation to Child: __________________

Cultural Background: _______________ Cultural Background: _______________

Preferred Pronouns: ________________ Preferred Pronouns: ________________

Who lives at home: ____

Custody arrangements/Court Orders: _____________________________________

Birth History:

Illness/Complications while pregnant: _______________________________________

Labor/ Delivery: ____

NICU/ICU stay: ____

Gestation at birth:____

Developmental History:

Previous Diagnosis: ____

Walked: ____

Talked: ____

Put phrases together: ____

Toilet Trained: ____

When did you first notice: ____

Medical History:

Current medications: ____

Hearing/Vision tests: ____

Reoccuring Ear Infections: ____

Asthma/Allergies: ____

Family History:

Is there anyone in your child's family who has a medical condition, disability, or difficulties? If yes, please provide details: ____

Have any of your child's siblings or family members been diagnosed with a developmental delay, intellectual disability or autism spectrum disorder? (If applicable)

☐ No ☐ Developmental delay ☐ Intellectual disability ☐ Autism spectrum disorder

Functional Behaviours:

How do they feed themselves: ☐ Cutlery ☐ With Hands ☐ Havent yet developed

How do they wash themselves: ☐ Independent ☐ With Support ☐ Havent yet developed

How do they dress themselves: ☐ Independent ☐ With Support ☐ Havent yet developed

Sleep: ☐ No concerns ☐ Some concerns ☐ Significant concerns

If significant concerns, please specify: _______________________________________

Is there variety in their diet: ☐ Yes ☐ Some concerns ☐ Significant concerns

If significant concerns, please specify: _______________________________________

Previous Therapies

Does your child has currently access or have they previously access the following services (If none apply please skip).

☐ Speech pathologist ☐ Physiotherapist ☐ Behaviour support/Psychologist ☐ Occupational therapist

☐ Nutritionist/Dietitian

☐ Other(s): ____

Did these services conduct any relevant assessments Yes ☐ No ☐

If yes, please specify ____