Initial Intake Form

Child's legal name:_____ Nickname: _____

Child's DOB: _____ Parent name(s): _____

Medical History

Pregnancy and birth history/complications (including NICU stay): _____

_____

Type of delivery: caesarian / vaginal / breech Length of pregnancy: _____

Current Medications: _____

Allergies: _____

Any previous surgeries, illnesses, hospitalizations? _____

_____

Formal Diagnoses: _____

Specialist(s) seen: _____

Previous therapies: _____

Current therapies (including EI or IEP): _____

Date of most recent hearing exam: _____ Outcome: _____

Date of the most recent vision exam: _____ Outcome: _____

Social History

Living with (include all household members and sibling ages): _____

_____

Daycare/School: _____ Grade: _____

Favorite toys/games/activities: _____

Developmental History

At what age did the child sit alone? _____ At what age did the child crawl? _____

At what age did the child walk? _____ At what age did the child use first words? _____

At what age did the child combine words? _____ At what age were solid foods introduced? _____

At what age were solid foods (including purées and baby foods) tolerated? _____

Main caregiver concerns: _____

Main pediatrician concerns: _____

Main teacher concerns: _____

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BOOST Kids PEDIATRIC THERAPY

Areas of concern for occupational therapy - please check all that apply

_____ fine motor skills & grasp patterns
_____ visual motor skills (coloring, drawing, cutting)
_____ handwriting
_____ motor planning (executing new tasks)
_____ self-care skills (dressing, grooming)
_____ eating habits/behaviors (picky eating, refusing to try new foods)
_____ self-regulation
_____ social skills / engagement
_____ strength and endurance
_____ sensory modulation / processing
_____ attention and focus
_____ coordination, posture, or balance

Areas of concern for speech and language - please check all that apply

_____ Articulation (producing speech sounds)
_____ Difficulty following MOST directions
_____ Difficulty following multistep directions containing concepts of time or location
_____ Difficulty responding to simple questions (who/what/where/when etc.,)
_____ Difficulty understanding verbal instructions
_____ Listening comprehension
_____ Difficulty formulating simple sentences
_____ Difficulty asking/answering questions
_____ Initiating conversation with peers
_____ Fluency (stuttering)
_____ Reading comprehension
_____ Responding to social cues

Is there a family history of speech or language disorders? Yes No

If yes, explain: _____

At what age did you or your child's pediatrician/educator notice and/or express concerns related to speech/language development? _____

Is your child aware of, or become frustrated by, his/her communication difficulties? Please explain.

_____

Does your child currently use any type of communication device? _____

If your child is under 4, approximately how many words do you believe your child has?

Can your child produce sentences with the following word lengths?

2 words	Yes	No	4 words	Yes	No
3 words	Yes	No	5+ words	Yes	No

If not currently using words, how does your child communicate? (ex: guiding, outbursts/meltdowns, completing tasks independently, pointing/gestures) _____

_____