SOL THERAPIES
1740 SE 18th Street, Suite 901, Ocala, FL 34471
sol.therapies.llc@gmail.com
☎ 352-327-8206 🖷 352-681-4077

PEDIATRIC CASE HISTORY
INTAKE FORM

Please answer the questions as fully and accurately as possible. The information that you provide on this form will help to create a better understanding of your child and the course of evaluation and treatment. If you are unsure of a particular answer, mark with a question mark (?). If a question is not relevant to your child, please write "N/A." All material and information is strictly confidential.

Patient's Name: _____ **Address:** _____
Date of Birth: _____
Age: _____ _____

GENERAL INFORMATION

Parent's Name:	Phone:
Occupation:	Email Address:
Parent's Name:	Phone:
Occupation:	Email Address:

What Languages Are Spoken in the Home?	What is the Child's Primary Language?

Referred By:	Phone:
Relationship:	Email Address:

Primary Doctor:	Phone:
Office Name:	

Dentist:	Phone:
Orthodontist:	Phone:

Additional Specialist:	Area:
Office Name:	Phone:

Additional Specialist:	Area:
Office Name:	Phone:

SERVICE REQUEST

□ Speech/Language	□ Feeding Therapy	□ Occupational Therapy	□ Co-Treatment (SLP and OT)
□ Deaf/Hard of Hearing	□ Assistive Technology	□ Educational Planning	□ Advocate Services

Preferred Days and Times

□ Mondays	□ Tuesdays	□ Wednesdays	□ Thursdays	□ Fridays
□ Mornings (7AM - 11AM)	□ Mornings (7AM - 11AM)	□ Mornings (7AM - 11AM)	□ Mornings (7AM - 11AM)	□ Mornings (7AM - 11AM)
□ Afternoons (11 AM – 3PM)	□ Afternoons (11 AM – 3PM)	□ Afternoons (11 AM – 3PM)	□ Afternoons (11 AM – 3PM)	□ Afternoons (11 AM – 3PM)
□ Evenings (3PM – 6PM)	□ Evenings (3PM – 6PM)	□ Evenings (3PM – 6PM)	□ Evenings (3PM – 6PM)	□ Evenings (3PM – 6PM)

FAMILY HISTORY

Child Lives With	☐ Birth Parents	☐ Adoptive Parents	☐ Foster Parents	☐ One Parent	☐ Split Custody	☐ Other

Sibling Name	Age	Same Household?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

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FAMILY HISTORY (cont.)

Have any close family members been diagnosed with the following		Family member(s)
Speech or Language Disorder	☐ YES ☐ NO	
Learning Disabilities (i.e. dyslexia)	☐ YES ☐ NO	
Hearing Impairment/Deafness	☐ YES ☐ NO	
Autism Spectrum Disorder	☐ YES ☐ NO	
ADD or ADHD	☐ YES ☐ NO	
Motor Planning Disorder	☐ YES ☐ NO	
Sensory Processing Disorder	☐ YES ☐ NO	

MEDICAL HISTORY

Length of Pregnancy	
Illnesses, accidents, medications, etc.,	
General Condition at Birth	
Please describe any complications	

Please check the corresponding box if your child has been diagnosed with the following (if applicable):

☐ ADD/ADHD	☐ Anxiety Disorder	☐ Asthma	☐Autism Spectrum Disorder
☐ Cleft Palate/Lip	☐ Color Blindness	☐ Ear Infections	☐ Frequent Colds
☐ Food Allergies	☐ Headaches	☐ High Fever	☐ Other Allergies
☐ Seizures	☐ Sinus Infections	☐ Sleep Apnea	☐ Muscular Dystrophy
☐ Tonsillitis	☐ Traumatic Brain Injury	☐ Concussion	☐ Cerebral Palsy
☐ Swallowing Problem	☐ Hearing Loss	☐ Acid Reflux	☐ Motor Planning Disorder
☐ Nerve Damage	☐ Developmental Delay	☐ Diet Restrictions	☐ Sensory Processing Disorder
☐ Down Syndrome	☐ Visual Impairment	☐ Intellectual Disability	☐ Other (Please Specify Below)

If any of the above have been checked, please provide the date of diagnosis and name of physician:

Has your child had any surgeries, major accidents or hospitalizations? Have they ever been under general anesthesia? Please Describe:

Is your child taking any medications? If yes, please list:

Has your child ever undergone genetic testing? If yes, please share the findings:

☐ Yes	☐ No	

Has your child had a hearing test? If so, when?

☐ Yes	☐ No	

Has your child had a vision test? If so, when?

☐ Yes	☐ No	

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DEVELOPMENTAL HISTORY

Provide the approximate age at which your child began to do the following activities:

Crawl:	Sit:	Walk:
Feed Self:	Dress Self:	Use Toilet:
Use Single Words:	Combine Words:	Use Sentences:

How does your child primarily communicate?

☐ Gestures	☐ Single Words	☐ Short Phrases	☐ Sentences	☐ Conversation
☐ Alternative and Augmentative Communication Device:				

Does your child use a pacifier, suck thumb, chew on clothing, chew on pens/pencils, or have an attachment to putting other objects in their mouth such as "chewlery" ? If yes, how often and under what circumstances?

☐ Yes	☐ No	

Does your child have any feeding or eating problems (e.g. very picky eater, any problems tolerating specific food textures, swallowing, drooling, chewing, ect.)? If yes, please describe:

☐ Yes	☐ No	

From what does your child primarily drink?

☐ Baby Bottle	☐ Sippy Cup	☐ 360 Cup	☐ Cup with Straw	☐ Open Cup
☐ NPO	☐ Standard Water Bottle	☐ Other		

Does your child have difficulty walking, running, or participating in any activities that require large muscle coordination? Do you feel your child is excessively clumsy?

☐ Yes	☐ No	

Does your child require assistance with daily living activities such as dressing, showering, use bathroom, feeding, etc.? If yes, please describe the level of assistance needed.

☐ Yes	☐ No	

Please share any additional information/ comments regarding your child's development that you feel is important:

EDUCATIONAL HISTORY

School:	School District:
Grade:	Teacher:

The child currently has:

☐ Individualized Education Plan (IEP) ☐ Service Plan ☐ 504 Plan ☐ N/A

Date of most recent meeting: _____

EDUCATIONAL HISTORY (cont.)

If they have an IEP or 504, what programs, services, or instruction do they receive? If not, do they receive special help or interventions in the classroom for academics or behavior to help them achieve success? Please describe:

Has your child been diagnosed with any type of learning disability? If so, please describe:

☐ Yes	☐ No	

Does/Did the child receive in school therapy services? (OT, Speech, Language, PT, Vision, etc.) If yes, please describe:

☐ Yes	☐ No	

How does the child interact with others (shy, aggressive, uncooperative, etc.)?

Has the child ever received private academic support services (tutoring)? If yes, please describe:

☐ Yes	☐ No
Provider:	

Has the child ever received private (not school) occupational, speech, or physical therapy services? If yes, please describe:

☐ Yes	☐ No
Provider:	

SENSORY INFORMATION

Does your child have a normal response to pain? (e.g. high pain tolerance, easily injured) If no, please describe.

☐ Yes	☐ No	

Is your child what you might call hyperactive (always moving, can't sit still)? Please describe.

☐ Yes	☐ No	

Does your child have difficulty paying attention/keeping focus for more than 30 minutes? Please describe.

☐ Yes	☐ No	

Does your child engage in any repetitive behaviors? (e.g. rocking in chair, picking nails, fixing hair, etc.) Please describe.

☐ Yes	☐ No	

Does your child have an adverse (negative) reaction to any of the following?

Loud Noises	☐ Yes	☐ No
Bright Lights	☐ Yes	☐ No
Certain Food Textures	☐ Yes	☐ No
Having Teeth Brushed	☐ Yes	☐ No
Having Face Touched	☐ Yes	☐ No
Having Hair Brushed	☐ Yes	☐ No
Tags in Clothes	☐ Yes	☐ No
Wearing Socks/Shoes	☐ Yes	☐ No
Wearing Tight Clothing	☐ Yes	☐ No
Car Sickness	☐ Yes	☐ No
Being Hugged	☐ Yes	☐ No
Using the Bathroom (home)	☐ Yes	☐ No
Using Public Restrooms	☐ Yes	☐ No

Animals (dogs, cats)	☐ Yes	☐ No
Sharing toys or activities	☐ Yes	☐ No
Playground swings	☐ Yes	☐ No
Dirt, Paint, etc., on hands	☐ Yes	☐ No
Large Crowds	☐ Yes	☐ No
Doctor's Office	☐ Yes	☐ No
Dentist's Office	☐ Yes	☐ No
New Routines	☐ Yes	☐ No
Separating from a familiar adult	☐ Yes	☐ No
Music playing on stereo, phone, etc.	☐ Yes	☐ No
Someone Singing	☐ Yes	☐ No
When asked to "clean up"	☐ Yes	☐ No
Adult given directives	☐ Yes	☐ No

ADDITIONAL INFORMATION

What are some of your child's strengths and accomplishments?

What are your goals for evaluation and therapy?

Please provide any additional information that might be helpful in the evaluation or remediation of your child's speech, language, fine motor, and/or sensory concerns.

AFFIRMATION OF INFORMATION

_____ I affirm that this packet has been completed accurately and to the best of my ability.

_____ I understand that I will receive an electronic copy of this form via email for my records.

_____ I understand that it is my responsibility to update my child's therapist with any changes to this form.

SIGNATURE

Person(s) Completing Form:

Relationship to Child:

Signature: Date: