



Pediatric Intake History & Questionnaire

Please fill out all appropriate sections.

Note: If desired, you may use "N" for no answers, and "Y" for yes answers.

All information contained in this document is strictly confidential

Today's date: _____

Name: _____ Date of Birth: _____

Parent or Guardian Names: _____

Pregnancy & Birth History

Is your child adopted? _____ If yes, at what age? _____

Domestic? _____ International - country: _____

Were there any complications during pregnancy (illness, infection, stress, etc.)? _____

If yes, please describe: _____

Circle one: Post mature Full term Premature Length of pregnancy (in weeks): _____

Complications during labor & delivery? _____ If yes, please describe: _____

Circle any applicable: Forceps? Vacuum? C-section?

Birth weight: _____ Length of hospital stay: _____

Any initial concerns with feeding or respiration? _____

Was your infant any of the following: Calm Fussy Colicky Easily comforted Hard to comfort

Sleep difficulties as an infant? _____

History of Torticollis or Plagiocephaly? _____

Early Developmental Milestones

As accurately as you can remember, at what age did your child...

Roll? _____ Sat alone? _____ Army crawled? _____

Crawled? _____ Cruised? _____ Walked? _____

Ride tricycle? _____ Ride 2-wheel bike? _____

Used writing utensil? _____ Scissors? _____
Hand preference? _____ Foot preference? _____

Do you have concerns about your child's development in any of these areas:

Speech or language Motor skills Social skills Sensory Behavioral Emotional

Medical History

Hospitalizations	
Reason	Date/Hospital

Other Serious Accidents/Illnesses	
Event	Date/Hospital

Does your child have any medical diagnosis? _____ If yes, please list: _____

History of ear infections? _____ If yes, describe ages & frequency: _____

Allergies? _____ Glasses? _____

History of seizures? _____ History of high fevers? _____

Respiratory infections? _____ Cardiac concerns? _____

Childhood Illness? <i>Circle any that apply</i>	Measles	Rubella	Chickenpox	Rheumatic Fever	Polio
Immunizations and dates?	Tetanus		Pneumonia		
	Hepatitis		Chickenpox		
	Influenza		MMR (<i>Measles, Mumps, Rubella</i>)		

Any medical precautions? _____

Does your child currently take any medications? _____ Any past medications? _____

Please provide name/dose/frequency: _____

Has your child had previous therapy? If yes, please list facility, services (OT, speech, PT, Psych, ABA, etc.) & approximate ages: _____

Has your child ever been in an intensive therapy/feeding program? _____

Please list relevant family history, genetic concerns, or traumatic events: _____

Feeding History

Was the child breast fed? If yes, any concerns? _____

How was the latch? _____

What was feeding schedule like? _____

If bottle fed, for how long? _____ Weaned (bottle/breast): _____

What size/shape/brand of nipple? _____

What is/was feeding like? (were they fussy, never satisfied, up often through the night to feed, etc.) _____

Any symptoms of dysphagia (i.e. loss of milk around the mouth, coughing, choking, heavy breathing post eating, respiratory infections, gagging, etc)? _____

Has your child had a recent video swallow study? _____

Was there aspiration or penetration noted on the study? _____

Please fax a copy of the records to our office, 616-724-4117.

Did your child use a pacifier? If yes, for how long? _____

What kind of pacifier was it (i.e Soothie, Nuk, etc)? _____

Does your child like to mouth objects or explore with their mouths? _____

What types of objects do they prefer? _____

Do they bite or chew on their nails/fingers? _____

Did they or do they suck their thumb? If yes, when did they stop? _____

Does your child bite or chew objects or clothing? _____

Does your child grind their teeth? _____

Does your child have any aversion to textures? _____

Does your child refuse to eat, spit out, or gag on foods based on the following:

Temperature Food texture Crunchy foods Chewy foods Food color
Intense flavors Mixed textures of foods

What textures do they prefer to eat or touch? (use soft, crunchy, mixed, puree, etc.): _____

Does your child have difficulty with any of the following:

Sucking through a straw Food falling out of mouth
Frequent choking Chewing Swallowing

What foods does your child currently eat consistently? _____

What foods are emerging (will eat sometimes)? _____

Are there any foods that your child used to eat in the past, but will no longer eat? _____

Is mealtime interrupted as a result of atypical eating patterns? _____

How long does your child sit at mealtime (in minutes)? 1-2 3-5 6-10 entire meal

How would you describe your child's feeding/diet? Please circle any that apply:

Normal Picky eater Restricted diet Poor nutrition Unsafe Limited Other

At which age did your child begin to feed him/herself independently with utensils? _____

Educational History

Early Intervention? If yes, please describe: _____

Preschool? _____ Age entered kindergarten: _____ Has any grade been repeated? _____

If your child is currently in school, the grade they are currently in: _____

The school they are currently attending: _____

Is schoolwork difficult? If yes, which subjects? _____

Does the client like school? _____ Any concerns? _____

Receive school-based therapy? If yes, type & frequency? _____

Movement Questionnaire

Please check all that apply. Does your child...

- _____ Become overly excited after movement activity
- _____ Seeks intense movement (spins, twirls, jumps, bounces, rocks, etc.)
- _____ Have difficulty staying still
- _____ Shake head vigorously, or assume an upside-down position frequently
- _____ Avoid moving equipment on the playground
- _____ Fear of heights, or cautious when climbing
- _____ Dislikes head being tipped backward (i.e. to rinse hair in bathtub)
- _____ Trips easily, appears clumsy, loses balance easily
- _____ Have poor negotiation on uneven terrain
- _____ Bumps head often; doesn't extend arms when pushing from behind
- _____ Dislikes riding in the car
- _____ Demonstrate excess dizziness or nausea from swinging, spinning, riding in car
- _____ Dislike riding in elevators or escalators
- _____ Appear to hold head, neck, and shoulders stiffly while moving

Body Awareness

Please check all that apply. Does your child...

- Slump in chair with a rounded back/head leaning forward
- Prop him/herself up on forearms for support while sitting to read/do homework
- Lock his/her joints (elbows or knees)
- Uses quick bursts of movements (rather than sustained movements)
- Use too much force while moving or when using an object
- Use too little force while moving or when using an object
- Crave wrestling or tumbling
- Plays roughly with people or objects
- Seeks opportunity to fall or crash into things
- Frequently request or give firm, prolonged hugs
- Walks on toes frequently
- Slaps, stomps, or drags feet when walking
- Drags hand or object along wall when walking
- Turns his/her whole body when looking at a person or object
- Collapses onto furniture
- Seem unresponsive to being touched or bumped
- Have an excessive reaction to unexpected or light touch
- Like to be wrapped tightly in a sheet or blanket
- Seek tight spaces to play, hide, or work
- Seems weaker or tires more easily than peers
- Leans on objects or people for stability
- Have trouble lifting heavy objects
- Sits on floor with legs in "W" position
- Tense when patted affectionately

Motor Skill Questionnaire

Please check all that apply. Does your child...

- Avoid busy, unpredictable environments
- Frequently change his/her grasp on pencils, eating utensils, or other tools
- Struggle with drawing or handwriting
- Struggle with copying
- Struggle using scissors
- Not use the other hand to stabilize the paper

- Have difficulty using two hands together to perform a task
- Demonstrate letter or number reversals when writing
- Demonstrate poor visual-motor coordination
- Seems disorganized when approaching a task
- Prefer to talk about/talk through a task, rather than do it
- Demonstrate poor motor skill and control when attempting new activities
- Seem to struggle following directions
- Seem to misunderstand verbal cues as they relate to his/her body movements
- Have difficulty on ascending stairs
- Have difficulty on descending stairs
- Have difficulty on gravel driveways
- Have difficulty hopping or jumping
- Have difficulty skipping or running

Visual Skill Questionnaire

Please check all that apply. Does your child...

- Not look when manipulating objects
- Turn the entire head when reading across a page
- Keep eyes too close to work
- Use peripheral vision more than central vision
- Demonstrate eyestrain after reading a short period of time (i.e. rubbing eyes, yawning, etc.)
- Have a short attention span in reading/copying
- Lose his/her place often during reading
- Use finger/marker to keep place while reading
- Re-reads or skips words while reading
- Duck or blink when a ball is thrown to him/her

Communication Questionnaire

Please check all that apply. Does your child...

- Follow directions easily
- Demonstrate the ability to identify objects by eye gaze, pointing, or bringing to you
- Identifies pictures when named

- _____ Follows novel commands
 - _____ Recognizes family members names
 - _____ Responds to simple questions
 - _____ Answers yes/no questions correctly
 - _____ Responds to wh- questions
 - _____ Uses consonant sounds such as t, d, n, b, p, m
 - _____ Talks rather than uses gestures
 - _____ Asks “what’s that?”
 - _____ Asks for “more”
 - _____ Names 5-7 objects upon request
 - _____ Uses words *examples:* _____
 - _____ Uses phrases *examples:* _____
 - _____ Uses action words (run, jump, play)
 - _____ Responds to greetings consistently
 - _____ Refers to self by pronoun consistently
 - _____ Uses plurals
 - _____ Counts to: _____
 - _____ Relates recent experiences through verbalization
- Imitates any of the following: (please circle)
- Words Noises Facial expressions

Dressing & Grooming Questionnaire

- Please check all that apply. Does your child...
- _____ Seem selective about types of clothing textures s/he will wear
 - _____ Express a desire to wear minimal clothing, regardless of weather
 - _____ Like to have clothing covering the entire body, regardless of weather
 - _____ Frequently adjust clothing, as if feeling uncomfortable
 - _____ Need to have socks be “just right” (no wrinkles or twisted seams)
 - _____ Leave clothing twisted on his/her body
 - _____ Wear shoes loose or untied
 - _____ Wear shoes on the wrong feet
 - _____ Tie his/her own shoes

Is your child able to perform...

_____ Upper body dressing (coat, shirt)

_____ Lower body dressing (pants, socks, shoes)

_____ Bathing

_____ Toilet training

_____ Toilet management

_____ Grooming (washing hands, washing hair, brushing teeth, combing hair)

Is your child able to independently navigate:

Zippers

Snaps

Buttons

Dislike/resist tactile feeling of any of the following:

Brushing teeth Bathing Brushing hair Washing face Haircuts Trimming nails Blowing nose

Avoid or fear any of the following:

Barber's clippers Dentist tools Electric toothbrushes Toilet flushing Hair dryer
Hand dryers Bath water running

Sleeping Questionnaire

What time does your child awaken? _____

What mood is your child in upon waking? _____

What time is your child put to bed? _____

What time does your child fall asleep? _____

Describe your child's sleeping arrangement: _____

Sleeping through the night at what age? _____

Does your child have difficulty with any of the following? Please circle.

Falling asleep

Staying asleep

Frequent night waking

Do family members have interrupted sleep as a result? _____

How many times per night does s/he wake? _____

What does your child do when s/he awakens? Please circle.

Whimper

Scream

Play with toys

Goes to parent's room

Put self back to sleep

What activities do you use to get your child back to sleep? Please circle.

Feeding

Singing

Humming

Rocking

Reading

Bouncing

Massage

Other: _____

Environmental Interactions

Please check all that apply. Does your child...

- Appear overly sensitive to pain
- Appear under-sensitive to pain
- Overly sensitive to lights/sunlight
- Dislike having eyes covered
- Avoid environments/objects with certain odors
- Seek environments/objects with certain odors
- Seem confused about the direction of sounds
- Hear sounds that others do not, or before others notice
- Cover his/her ears to shut out auditory input
- Overreact to unexpected noises

Have difficulty with any of the following different types of voices:

Loud voices Men's voices Women's voices Children's voices Screaming Crying

Demonstrate an irrational fear of any of the following noisy sounds:

Vacuum cleaner Fans Blender Coffee Grinder Hair dryer Dehumidifier
Toilet flushing Air vents Jet/sAirplanes Trucks Thunder/lightning

Have difficulty with any of the following public places:

Grocery store Sporting event Shopping mall Other: _____

Family Interactions

Who are the most important people in your child's life? _____

Please check all that apply. Is your family...

- Limited in attending family/social gatherings because of your child's reactions/behaviors
- Having difficulty maintaining relationships with other families because of your child
- Having difficulties pursuing hobbies and interests because of your child
- Unable to attend birthday parties with/for your child
- Unable to eat out at restaurants
- Able to leave your child alone with familiar, but not routine, caregivers/childcare
- Having challenges with sibling behaviors/relationships as a result of your child's behavior

Play Skills

What are your child's favorite activities at home? _____

Please check all that apply. Does your child...

- Seem destructive towards toys
- Exhibit poor safety awareness/engage in activities that are potentially dangerous
- Have difficulty standing in line
- Prefer to play with adults instead of peers
- Seek adults on the playground
- Have a strong desire for structure or control within play
- Resists new physical challenges, saying "I can't" without attempting
- Seeks sedentary play
- Enjoy manipulative, puzzles, constructive toys (i.e. legos)
- Attempt to control or manipulate environment to keep it predictable
- Struggle to play in familiar settings
- Struggle to play in unfamiliar settings
- Struggle playing next to others (parallel play)
- Struggle interacting with peers in a play setting
- Struggle playing in a structured group (i.e. mom's group, gymnastics class, etc.)
- Struggle engaging in pretend (symbolic) play with peers

How long is your child able to play alone? Circle one (in minutes):

1-2

2-5

5-10

10-30

30+

Social Skills & Interactions

Please check all that apply. Does your child...

- React negatively to social touch or hugs from others (i.e. affectionate pats)
- Exhibit aggressive behavior directed towards him/herself
- Exhibit aggressive behavior directed towards others
- Appear to get easily frustrated, anxious, or overwhelmed
- Appear to be a poor loser
- Regularly avoid initiation of social interactions
- Regularly avoid maintaining social interactions

_____ Appear to have difficulty making friends
_____ Easily escalate from whimper to intense cry
_____ How does your child handle separation/transitions?

Make eye contact during conversation (circle one):

Less than 25% of time 25% of time 50% of time 75% of time Most of the time

Circle and/or describe your child's typical temperament in relation to their:

Energy level Sedentary Active Very Active

Describe: _____

First reaction (to new people, activities, ideas) Avoidance Shy Outgoing

Describe: _____

Mood (general emotional tone) Anxious Timid Curious Serious Happy

Other: _____

Intensity (strength of emotional reactions) Withdraw Mild reactions Strong reactions

Describe: _____

Parenting Comments

How would you describe parenting your child? _____

What do you find the most challenging or stressful in working with your child? _____

What has been the most joyful part of your relationship with your child? _____

Is there anything else you would like us to know about your child? _____

