Family Tree Therapies
identify. understand. empower.

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? *Circle any that apply*	Measles Rubella Chickenpox Rheumatic Fever Polio	
Immunizations and dates?	Tetanus	Pneumonia
	Hepatitis	Chickenpox
	Influenza	MMR *(Measles, Mumps, Rubella)*

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 mainlining 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? _____

_____

_____