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: _____

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

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

_____

Check 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

Describe your child's experience with tummy time: _____

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 ☐ Chewy foods ☐ Crunchy foods

☐ Mixed textures of foods ☐ Food color ☐ Intense flavors

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 check 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…

- ☐ Have difficulty responding to simple questions
- ☐ Have challenges answering yes/no questions correctly
- ☐ Have difficulty following directions at school/home
- ☐ Have challenges identifying objects/toys by name
- ☐ Have trouble staying engaged in conversation
- ☐ Have trouble taking the perspective of others
- ☐ Have difficulty with pronouns (me, you, mine, I, she, he, his, hers)
- ☐ Have difficulty with transitions (leaving house, mealtime, bedtime)
- ☐ Have challenges using language to communicate emotions
- ☐ Have difficulty responding to wh- questions
- ☐ Have trouble staying engaged in conversation
- ☐ Lacks gestures (doesn't point to him/herself and others, uses hands to help their message)
- ☐ Have difficulties asking for help/clarification questions
- ☐ Have challenges using language for requesting (uses body/grabbing/physicality)
- ☐ Have challenges with sequencing events verbally/telling stories
- ☐ Have difficulty making/keeping friendships
- ☐ Have difficulty reading facial expressions

Please list sounds that you hear your child attempting/making if applicable for age *examples* :

Please list words used at home if applicable for age *examples* :

Please list phrases used at home if applicable for age *examples* :

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 check.

☐ 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? _____

Does your child breathe audibly while sleeping? _____

Does your child breathe through their mouth at night? _____

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

☐ 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 check.

☐ 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? Check 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 (check one):

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

Check 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?