Providing services in:
Physical Therapy
Occupational Therapy
Speech/Language Pathology
Hydrotherapy
Special Therapy Programs

Family Achievement Center Inc.

PATIENT INTAKE FORM - CHILD

Date:_____

Name:_____ DOB:_____ Age:_____
Medical Diagnoses (of any kind): _____
_____
Educational Diagnoses:_____

Reason for evaluation –
Parental concerns: _____
_____
Recommendation from other professional(s)/parent(s)? What concerns were shared with you and by whom? _____
_____
_____

GENERAL INFORMATION:

Please list any allergies, medications, dietary guidelines, or medical precautions for your child:

Does your child receive speech, occupational, or physical therapy at this time?
Speech __x/week
OT __x/week ____ No Services at this time.
PT __x/week
Has your child received speech, occupational or physical therapy in the past?
___ Yes Speech/PT/OT Date services ended_____ ___ NO

Has your child received cognitive/intelligence/psychological testing?
___ Yes Impaired/Within Normal Limits ___ NO

Has your child received a hearing screen or formal hearing evaluation?
___ Yes Impaired/Within Normal Limits ___ NO

Has your child received a vision screen or formal vision evaluation?
___ Yes Impaired/Within Normal Limits ___ NO

If you have the results of these evaluations, please attach.

8320 City Centre Drive, Suite G Woodbury, MN 55125
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FAMILY HISTORY:

Parent's name:_____ Parent's name:_____
Parent's name:_____ Parent's name:_____

Siblings Name and Age:

_____

Who currently lives with this child?

_____

History:

Were there any issues with the pregnancy and delivery of your child?

Were there any feeding difficulties after birth including problems sucking or nutrient intake? Please specify.

Has your child had any significant childhood illnesses? If so, please be specific.

Does your child experience frequent ear infections? Does he/she have P.E. tubes? Permanent or temporary? If so, what ears?

Does your child use any adaptive equipment?

The following questions are utilized as a tool in order to get a more complete picture of your child. **Some of the questions may refer to children that are older than your own**. Check the choice that applies:

Developmental History: Did your child reach developmental milestones at appropriate times? (if no, specify age milestone was met)	YES	NO	AGE
Roll (5-6 months)			
Sit independently (6-8 months)			
Crawl (9-11 months)			
Walk (12-15 months)			
First Word (12 months)			
2-3 word sentences (18 months)			
Drink from a cup independently (12-16 months)			
Feed self independently (2 ½ - 3 years) What type of utensils?			

Behavior/Temperament Questions	YES	NO	COMMENTS
Describe your child at present:			
Mostly quiet ,calm, patient			
Hyperactive, always in motion			
Rigid, set in his/her ways			
Upset by transitions/unexpected changes			
Short attention span			
Impulsive			
Over reacts			
Exhibits frequent temper tantrums			
Has difficulty separating from primary caretaker			
Has nervous habits or tics			
Regular sleep patterns			
Difficult to get to sleep			
Is frustrated easily			
Has unusual fears			
Has a difficult time in public places			
Has difficulty learning new tasks (i.e writing, throwing a ball, riding a bike, etc)			
Very cautious with trying new things			
Has poor safety awareness			

Does our child play with toys differently than his or her peers? Please describe the difference.

Family History:

Do any of your child's siblings receive therapy services or have a related diagnosis

School Services:

Does your child have an IEP, IIIP, or IFSP? YES NO

If YES, then:

- Type of Service(s) Received: OT PT ST
- Frequency and Duration of Session: (eg., ___Min. Direct, ___Min. Indirect, for each discipline)
  OT=
  PT=
  ST=

- Individual or Group Setting (for each discipline):
  OT _____ PT _____ ST _____

Please bring a copy of the IEP, IIP, or IFSP to the appt.

Name of School	
Grade	
List Goals	

Additional Questions:

What does your child like to do?

What does your child dislike?

Is your child currently active in any extracurricular/recreational activities? If so, what

Therapy goals and additional comments or concerns

Thank you for taking the time to complete this form. It is greatly appreciated and will be helpful in completing your child's evaluation here at Family Achievement Center.

OCCUPATIONAL THERAPY PATIENT INTAKE FORM – CHILD

Functional Status	YES	NO	If, no how much assistance they need? 100%	75%	50%	25%	10%
Independent with dressing							
Independent with toileting							
Independent with grooming (brush teeth, comb hair, wash face)							
Independent with bathing/showering							
Independent with self-feeding							
Can independently fix a snack							
Gross/Fine Motor			**Comments**				
Gets tired easily playing or writing							
Seems generally weak compared to peers							
Has difficulty playing on playground equipment							
Seems clumsy, awkward							
Has poor ball skills (catching, dribbling)							
Have poor handwriting							
Has difficulty with buttons, zippers, & snaps							
Vision							
Rubs eyes while working							
Poor reading comprehension							
Eyes are tired at the end of the day							
Trouble copying from board							
Holds things very close to eyes							
Complains of eyestrain, headaches							
Makes reversals when copying or reading							

Goal Areas:

In the area of occupational therapy (ex "dress independently, tolerate more sensory experiences, use his/her hands better…")

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SPEECH THERAPY PATIENT INTAKE FORM – CHILD

Please answer the following questions to the best of your ability and make comments as appropriate.

Please describe the concerns you have regarding your child's speech and/or language. Give examples of their difficulties.

How does your child make his/her needs and wants known?

Was your infant…	A quiet baby?	YES	NO
	A frequent crier?	YES	NO
	Irritable?	YES	NO
	Visually alert/attentive?	YES	NO
	Auditorily alert/attentive?	YES	NO

At what age did your child…

Babble? _____
Understand speech sounds? _____
Imitate speech sounds? _____
Say first words? _____
Use two or more words in phrases? _____

At present, does your child have:	Understandable speech?	YES	NO
	A loud voice?	YES	NO
	A monotone voice?	YES	NO
	A hoarse voice?	YES	NO

Please describe when you first noticed something was different about the way your child communicates. When did the change occur and what do you think brought on the change?

How intelligible is your child to family members? To others?

Do any of your child's siblings receive therapy services or have a related diagnosis?

Is there any history of speech, language or stuttering difficulties in your family? If so, who and what is their relationship to the child.

In the next several months in the area of speech/language, I would like my child to be able to (ex "talk clearly, use more words, follow directions. . ."):

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