Momentum Therapy Center

Today's Date: _____

**Pediatric Intake Form**

Welcome to Momentum Therapy Center. The information you provide on this form will help us prepare your child's upcoming speech-language and/or feeding evaluation. Please print and complete the form to the best of your ability. Mail or fax this form before the evaluation date.

Child's Name: _____ Gender: _____ Age: _____

Birthdate: _____

Mother's Name: _____ Home Phone: _____ Cell: _____

Email address: _____

Father's Name: _____ Home Phone: _____ Cell: _____

Email address: _____

Home Address: _____

Who is filling this questionnaire? _____ Relationship to child: _____

Medical or Developmental diagnosis: _____

School Diagnosis: _____

Who referred your child? _____

Reason for referral: _____

_____

When did you first notice the issue(s)? _____

**Family Information**

Father's Occupation: _____

Mother's Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Siblings:

Name: _____ Age: _____

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Name: _____ Age: _____

Name: _____ Age: _____

Who currently lives in the home? _____

Primary language spoken at home: _____

Are there any family members or relatives who have or had any speech, language, swallowing/feedings, issues or therapy? If yes, why? _____

**Pregnancy, Birth History, and Early Development**

Is this your biological child? _____

Were there any complications during pregnancy? _____ If yes, explain? _____

_____

Type of Delivery: ☐ Vaginal ☐ Cesarean section

Was the child born before 37 weeks gestation? ☐ Yes ☐ No

Any complications during delivery? ☐ Yes ☐ No

If yes, please describe below _____

_____

Child's Birth weight? _____

Did the baby have trouble breathing? ☐ Yes ☐ No

If yes, please describe below _____

_____

Was the baby on a respirator? ☐ Yes ☐ No

If yes, how long? _____

**Feeding:**

Was feeding a problem? ☐ Yes ☐ No

If yes, please describe below _____

Breast-fed? _____ Age weaned from breast _____

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Bottle-fed? _____ Age weaned from bottle?_____

Age drank independently from an open cup _____

Finger fed self? _____

Is your child able to eat with a spoon and fork? _____

Does your child have any problems eating now? _____

Is he/she a picky eater? ☐ Yes ☐ No

If yes, please describe below _____

Did the baby have reflux? _____ If yes, please describe severity and treatment: _____

Does your child eat pureed foods? (Yogurt, pudding) _____

Does your child eat crunchy foods? (Cookies, pretzels):_____

Does your child:

- Choke or cough on foods or liquids? ☐ Yes ☐ No
- Puts toys/objects in his/her mouth? ☐ Yes ☐ No
- Brush or allow someone to brush his/her teeth? ☐ Yes ☐ No
- Gag? ☐ Yes ☐ No
- Self-feed? ☐ Yes ☐ No

Has your child ever had a swallow study? ☐ Yes ☐ No

If yes, date of last exam _____Where? _____

Results: _____

**Motor Development:**

Was your child very active as a baby? _____

When did your child first learn to?

| Roll over: | Take first step: |
|---|---|

| | |
|---|---|
| Sit up: | Walk: |
| Crawl: | Smile: |
| Stand alone: | Dress self: |

How well does your child: Walk? _____ Run? _____

Throw a ball? _____

Dominant hand? ☐ Left ☐ Right ☐ Ambidextrous (both)

If your child has difficulties with any of the above or any other motor activities, please describe below

_____

Is your child toilet trained? _____ If so, at what age? _____

Does your child wet the bed? _____ If so, how often? _____

**Communication Development:**

Was your child a very quiet baby? _____

Did/Does your child?

- Coo ☐ Yes ☐ No
- Babble ☐ Yes ☐ No
- Cry expressively? ☐ Yes ☐ No
- Repeats sounds, words, or phrases over and over? ☐ Yes ☐ No
- Understand spoken language? ☐ Yes ☐ No
- Retrieve or point to common objects upon request? ☐ Yes ☐ No
- Follow simple instructions? ☐ Yes ☐ No
- Respond to yes/no questions? ☐ Yes ☐ No
- Respond appropriately to who, what, where, why, how, questions? ☐ Yes ☐ No

How does your child communicate?

- Use pointing and gesturing? ☐ Yes ☐ No
- Single word? ☐ Yes ☐ No
- Gestures more often than words? ☐ Yes ☐ No
- 2-4 word phrases/sentences? ☐ Yes ☐ No

- 5+ word sentences? ☐ Yes ☐ No
- Complete sentences? ☐ Yes ☐ No
- If your child talks now, can you understand? ☐ Yes ☐ No
- Can family members understand? ☐ Yes ☐ No
- Can strangers understand? ☐ Yes ☐ No
- Does your child stutter? ☐ Yes ☐ No
- Other: please describe _____

**Reading and Writing:** (If age appropriate, please complete)

Has your child had any problems learning to read? ☐ Yes ☐ No

If yes, explain: _____

Has your child had any problems learning how to write? ☐ Yes ☐ No

If yes, explain: _____

Do you/Did you read to your child? ☐ Yes ☐ No

Does/Did your child enjoy being read? ☐ Yes ☐ No

What does your child enjoy reading? _____

What does your child dislike reading? _____

Does your child known the alphabet? ☐ Yes ☐ No

Does your child have difficulty learning/using new words? ☐ Yes ☐ No

If yes, explain: _____

Does your child have difficulty learning/retaining new information?

☐ Yes ☐ No

If yes, explain: _____

Can your child write well for his/her age? ☐ Yes ☐ No

MATH (If age appropriate, please complete)

Has your child had difficulty learning math? ☐ Yes ☐ No

If yes, explain: _____

Has your child like math? ☐ Yes ☐ No

If no, explain: _____

**Cognitive Development:**

Which toys did your child play with at age 12-18 months? _____

_____

Which toys did your child play with at age 24-36 months? _____

_____

Does your child play with toys now? ☐ Yes ☐ No

If yes, describe _____

How does your child learn? _____ Quickly? _____Slowly? _____Average?

Please describe _____

Does your child have difficulty solving everyday problems? ☐ Yes ☐ No

If yes, describe _____

Does your child have difficulty following multi-step directions? ☐ Yes ☐ No

If yes, describe _____

**Medical History:**

Pediatrician's Name: _____

Address: _____

Phone number: _____ Fax number: _____

Diagnosis (es): _____

Specialists (ex. Neurologist, Nutritionist, Allergist): _____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please describe below _____

Has your child ever fainted? ☐ Yes ☐ No

Has your child ever had seizures? ☐ Yes ☐ No

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Does your child have trouble hearing? ☐ Yes ☐ No

Has your child had ear infections? ☐ Yes ☐ No

If yes, how many? _____

Has your child had middle ear tubes inserted? ☐ Yes ☐ No

If yes, when? _____

Has your child had his/her adenoids removed? ☐ Yes ☐ No

If yes, when? _____

Does your child have any trouble sleeping at night? ☐ Yes ☐ No

If yes, please describe _____

Does your child have trouble waking up in the morning? ☐ Yes ☐ No

If yes, please describe _____

Does your child wet the bed? ☐ Yes ☐ No

If yes, how often? _____

Does your child have allergies? ☐ Yes ☐ No

If yes, please describe _____

Does your child have asthma? ☐ Yes ☐ No

Did the baby had any medical problems in the first year of life? ☐ Yes ☐ No

If yes, please describe _____

Please check the illnesses the child has had in the past. Also, indicate the child's age at the last occurrence and note any hospitalizations due to illness:

| **Illness** | **Yes** | **No** | **Age** | **Hospitalization** |
|---|---|---|---|---|
| Measles | | | | |
| Chicken Pox | | | | |
| Mumps | | | | |
| Streptococcal (Strep) Throat | | | | |

| | | | | |
|---|---|---|---|---|
| Scarlet Fever | | | | |
| Tonsillitis | | | | |
| Ear Infection | | | | |
| Seizures | | | | |
| Meningitis | | | | |

Were any of these illnesses followed by noticeable changes in the child's typical behaviors?

☐ Yes ☐ No

If yes, please describe below _____

Has your child had any surgeries? ☐ Yes ☐ No

If yes, please describe below _____

_____

Medication Profile: Please list all current and past medications and reason for medication

| Past Medications | Reason |
|---|---|
| | |
| | |
| | |

| Current Medication | Reason |
|---|---|
| | |
| | |
| | |

**Dental:**

Does your child have any dental problems? ☐ Yes ☐ No

If yes, please describe _____

Has your child had a dental exam? ☐ Yes ☐ No

If yes, date of last exam _____

Where? _____ Results? _____

**Vision:**

Does your child have any vision problems? ☐ Yes ☐ No

If yes, please describe _____

Does your child use glasses/contacts? ☐ Yes ☐ No

If yes, please describe _____

Has your child had a vision exam? ☐ Yes ☐ No

If yes, date of last exam _____

Where? _____ Results? _____

**Hearing:**

Does your child have any hearing problems? ☐ Yes ☐ No

If yes, please describe _____

Has your child had a hearing test? ☐ Yes ☐ No

If yes, date of last exam _____

Where? _____ Results? _____

Does your child use a hearing aid? ☐ Yes ☐ No

If yes, when does your child use it? _____

**Developmental Evaluations:** Has your child had the following evaluation?

Psychological Evaluation? ☐ Yes ☐ No

If yes: _____

Name of Doctor Location of Evaluation Date

Describe results of evaluation: _____

Occupational Therapy? ☐ Yes ☐ No

If yes: _____

Name of Evaluator Location of Evaluation Date

Describe results of evaluation: _____

Physical Therapy? ☐ Yes ☐ No

If yes: _____

Name of Evaluator Location of Evaluation Date

Describe results of evaluation: _____

Speech and Language? ☐ Yes ☐ No

If yes: _____

Name of Evaluator Location of Evaluation Date

Describe results of evaluation: _____

Feeding/Swallowing? ☐ Yes ☐ No

If yes: _____

Name of Evaluator Location of Evaluation Date

Describe results of evaluation: _____

Developmental Evaluation? ☐ Yes ☐ No

If yes: _____

Name of Evaluator Location of Evaluation Date

Describe results of evaluation: _____

Neurological Evaluation? ☐ Yes ☐ No

If yes: _____

Name of Doctor Location of Evaluation Date

Describe results of evaluation: _____

Other Evaluations? ☐ Yes ☐ No

If yes: _____

Name of Doctor/Evaluator Location of Evaluation Date

Describe results of evaluation: _____

**Therapy Services:**

Please list the therapy services that your child currently receives. Please include number of hours per week.

-Type of therapy: _____ Therapist: _____

Address: _____

Phone number: _____ Hours per week: _____

-Type of therapy: _____ Therapist: _____

Address: _____

Phone number: _____ Hours per week: _____

-Type of therapy: _____ Therapist: _____

Address: _____

Phone number: _____ Hours per week: _____

**Additional Information**

Does your child understand English? ☐ Yes ☐ No

Does your child speak English? ☐ Yes ☐ No

What language(s), other than English, is spoken at home? _____

What language do the parents prefer to speak? _____

Does your child currently attend another program? ☐ Yes ☐ No

If yes, where? _____

What does your child like to do? _____

What frightens your child? _____

What is your child's sleeping/napping schedule? _____

_____

Is your child aware of, frustrated by, any communication difficulties? _____

_____

Do you feel your child has sensory issues? Please describe _____

_____

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Does your child have any duties/chores at home? Please describe _____

_____

List the places that your child frequently visits _____

_____

List the important people in your child's life and name what she/he calls them: _____

_____

What do you see as your child's most difficult problem at home? _____

_____

Do you feel your child is developing at the same rate as his peers (socially, play skills, self-help skills, etc.)? Please describe _____

_____

**Play Skills:** Please check all that apply.

- ☐ Places objects in mouth
- ☐ Bangs items or his/her head
- ☐ Stacks blocks
- ☐ Manipulates knobs/buttons
- ☐ Pretends to sleep
- ☐ Feeds doll, stuffed animal, etc.
- ☐ Moves toy cars/animal with appropriate sounds of vehicle/animal
- ☐ Combines ideas (ex. Feeds dolls and puts to sleep)
- ☐ Plays or scenarios/role plays, 3-4 steps (ex. Sets the table, pretends to cook foods, eats food)

**Social History:**

Name of the school your child currently attends _____

Teacher's Name: _____ Grade: _____

Has your child repeated a grade? ☐ Yes ☐ No

If yes, what grade? _____

What are your child's strengths and/or best subjects? _____

_____

**Behavior Characteristics:** Please check all that apply.

| | | | |
|---|---|---|---|
| | Cooperative | | Attentive |
| | Willing to try new things | | Spends nights away from home |
| | Plays alone for _____ minutes at a time | | Destructive |
| | Separation difficulties | | Aggressive |
| | Picky eater | | Withdrawn |
| | Easily frustrated | | Attends summer camp |
| | Impulsive | | Participated in family trips/activities |
| | Uses language fluently | | Cares for pets |
| | Stubborn | | Short attention span/Easily distracted |
| | Poor eye contact | | Attends religious/spiritual gatherings |
| | Inappropriate behaviors. Please describe: | | |
| | Self-abusive behaviors. Please describe: | | |
| | Has nervous tendencies (ex. Unusual fears, temper tantrums, extreme moods). Please describe: | | |

Primary reason for seeking therapy_____

_____

_____

What is your vision or goal for your child's individual education and emotional needs? _____

_____

_____

_____