PHYSIOTHERAPY & OCCUPATIONAL THERAPY PROGRAM

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INTAKE FORM

Child's Name: _____D.O.B._____Gender:_____

Do you have extended benefits: Yes / No Provider Info: _____

Information provided by: _____ Relationship to Child: _____

Date completed: _____

Section #1 Child Profile and Goals for Treatment:

What are your child's needs or areas of concern?

What would you describe as your child's gifts/strengths?

What kinds of activities does your child seem to enjoy best? How do they like to play?

What are your goals for therapy? (e.g. what skills or behaviours do you hope to see developed in your child?)

Section #2 Family, Pregnancy and Birth History: *Please note, this information is confidential and is gathered to help us understand how best to help you and your child.*

1. Is there a family history of problems regarding:

- ☐ vision
- ☐ hearing
- ☐ speech/language
- ☐ learning disabilities
- ☐ bones & joints
- ☐ genetic/familial disorders
- ☐ allergies
- ☐ mental health
- ☐ post-partum anxiety/depression
- ☐ other

2. Did any of these risk factors occur during pregnancy:

- ☐ illnesses
- ☐ trauma/injuries
- ☐ bleeding
- ☐ excessive weight gain
- ☐ lack of weight gain
- ☐ high blood pressure
- ☐ medications
- ☐ drug use
- ☐ alcohol use
- ☐ diabetes
- ☐ anemia
- ☐ R H incompatibility
- ☐ reduced fetal movement
- ☐ previous miscarriage
- ☐ toxemia/pre-eclampsia
- ☐ abuse/violence
- ☐ smoking
- ☐ other

3. Were there any complications during delivery:

- ☐ fetal distress
- ☐ rapid labor
- ☐ premature labour
- ☐ breech/malposition
- ☐ excessive bleeding
- ☐ birth asphyxia
- ☐ forceps/vaccum
- ☐ other

4. Please provide the following labor and birth details:

Length of labor: _____ Birth weight: _____ Single/Twin: _____
Gestational age: _____ C-section/Vaginal: _____ Apgars: _____

Section #3 Child's Medical History and Development:

1. **Has your child had:**

- □ A hearing check
- □ A vision check
- □ Up to date immunizations
- □ Any medical/special tests

2. **Current medical issues/medications:**

3. **Did you have any concerns related to your child's early development?**

- □ major illness/surgery
- □ hospitalizations
- □ accident/injuries
- □ seizures
- □ jaundice
- □ apnea
- □ poor weight gain
- □ difficulty breast feeding/latching
- □ reflux/gastric issues
- □ difficulty breathing
- □ history of ear infections
- □ other

4. **Please tell us at what age your child first:**

Rolled:	Crawled:	Walked alone:
Smiling at you:	Pulled to stand:	Rode a tricycle:
Babbled/cooed:	Pointed at toy:	Toilet trained:
Sat alone:	Used single word:	Drank from a cup:
Reached for a toy:	Two words together:	Used spoon:

(It's OK to leave some blank – please fill out the ones you remember)

Section #4: Daily Activities

1. **Do you have concerns about any of the following areas:** *(if so, please comment)*

- □ toileting / potty training
- □ teeth brushing
- □ bathing
- □ getting dressed
- □ feeding/mealtimes
- □ sleeping

Section #5: Sensory and Social/Emotional:

1. Has your child recently experienced any major life changes or other stressors?

2. What things does your child find frustrating or frightening? How do you know this?

3. How do you comfort your child? How long does it take for them to settle down?

4. Check if your child has difficulty with any of the following:
   - □ transitions to new activities
   - □ learning something new
   - □ communicating their needs
   - □ social interactions with other children
   - □ participating in childcare settings
   - □ expressing their emotions

5. My child seems to be ***overly sensitive*** to these sensory experiences: *(check any that apply)*

□ loud noises □ touch □ bright lights □ spinning/swings □ strong smells

6. My child ***doesn't seem to react*** to these sensory experiences: *(check any that apply)*

□ loud noises □ touch □ bright lights □ spinning/swings □ strong smells

Section #6 Other Considerations

1. List the people currently living in the home with the child:

2. Do you have a cultural background or any spiritual beliefs that you would like us to consider within therapy?

3. Do you have a need for other services or supports?