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Pediatric Intake Form

Child's name: ______________________ DOB: __________ Age: ________ Ⓜ Ⓕ
Current Diagnosis: ____
Home Address: ______________________ City: ______________ Zip: __________
School Attendance History: ______________________________ Grade: __________

Parent/Guardian #1 name: ______________________ Occupation: ______________
Relationship to Child: ______________________ Custody Status: ______________
Home Address (if different from above): ______________________________
Preferred Phone Number: ______________ Home/Work/Cell Email: ______________

Parent/Guardian #2 name: ______________________ Occupation: ______________
Relationship to Child: ______________________ Custody Status: ______________
Home Address (if different from above): ______________________________
Preferred Phone Number: ______________ Home/Work/Cell Email: ______________
Emergency Contact: ______________ Relationship: ______________ Phone: __________

Primary Language: ______________ Language Spoken at Home: ______________
Child's Primary Physician: ______________ Address/Phone: ______________
Child's Referring Physician: ______________ Address/Phone: ______________
Reason for Referral: ____

Is there a joint-custody or parenting plan in effect? ☐ Yes ☐ No
Is there a restraining order in effect? ☐ Yes ☐ No
Is the restraining order against: ☐ Mother ☐ Father ☐ Other: ______________

What are your primary areas of concern/What are you hoping for the therapist to address?

____
____
____
____

What are your goals for therapy?

____
____
____
____

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Does your child ever complain of pain? If so, in what area? Please describe:

Please list any medical precautions/allergies/medications:

Is your child receiving any other services? (i.e. Speech Therapy, Physical Therapy, Occupational Therapy, Special Education, Early Intervention)

What (if any) special equipment does your child use?

☐ Wheelchair
☐ Eye glasses
☐ Hearing Aids
☐ Braces
☐ Walker
☐ Crutches
☐ Communication Device
☐ Other:

Please list any significant prenatal or birth history:

☐ Premature (Gestation: ________weeks)
☐ Full Term
☐ Low Birth weight (__________lbs)
☐ Breech Birth
☐ C-section Birth (Planned)
☐ Emergency C-Section
☐ Vaginal Birth
☐ Forceps Delivery
☐ Vacuum Delivery
☐ Preeclampsia
☐ Gestational Diabetes
☐ Breast Fed
☐ Poor suction/latch
☐ Bottle Fed
☐ Multiple Ultrasounds
☐ Oxygen at Birth
☐ NICU Stay (Duration in NCIU:____________)
☐ Other:_______________

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Pediatric Intake Form

Medical History

Please list any significant illness, hospitalizations, etc.:

____

____

____

____

- ☐ Chronic ear infections
- ☐ Tubes
- ☐ Tonsils/Adenoid Surgery
- ☐ Reflux
- ☐ Surgeries (list above)
- ☐ Poor weight gain
- ☐ Colic
- ☐ Poor Sleep
- ☐ Asthma
- ☐ Lyme Disease
- ☐ Abnormal Muscle Tone
- ☐ Torticollis
- ☐ Frequent Antibiotic Use
- ☐ Frequent Fevers
- ☐ Compromised Immune System
- ☐ Abnormal Lab Results
- ☐ Cardiac Issues
- ☐ Other:______________

Developmental History

Fill in the blanks to describe your child to the best of your ability:

Sat at __________months/years
Crawled at __________months/years
Stood at __________months/years
Walked at __________months/years
Ran at __________months/years
Dressed at __________months/years
Toilet trained at __________months/years
Fed self at __________months/years
First single words at __________months/years
Put words together at __________months/years
Making sentences at __________months/years

Please list any motor development concerns you have. (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc.)

____

____

Please list any concerns with feeding/eating or allergies.

____

____

- ☐ Was placed on his/her belly as an infant
- ☐ Enjoyed belly time as an infant
- ☐ Met all motor milestones on time
- ☐ Is athletic/plays sports
- ☐ Is good negotiating playground equipment
- ☐ Is good with his/her hands (fine motor skills)
- ☐ Was not placed on his/her belly as an infant
- ☐ Did not tolerate being placed on his/her belly as an infant
- ☐ Was late to:__________________________
- ☐ Was/is developmentally delayed
- ☐ Is clumsy
- ☐ Avoids climbing, swinging, sliding
- ☐ Gets overwhelmed in public places

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Speech/Language Development

What is your child's primary mode of communication? (Gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange. etc)

____

____

How does your child get his/ her needs met? (Pointing, grunting, taking item to you, requesting verbally, etc.)

____

____

Please give an estimate of how many words are in your child's vocabulary:

Receptive (words understood): ____________

Expressive (words spoken): ____________

How much of your child's speech do you understand?

☐ 10% or less ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100%

Are there any sounds your child has difficulty with? Please list:

____

____

How much of your child's speech do others understand?

☐ 10% or less ☐ 11-24% ☐ 25-50% ☐ 51-74% ☐ 75-100%

Does your child demonstrate frustration when he/she is not understood? If yes, please explain.

____

____

Is your child able to follow directions? (1 and 2 step?)

____

____

Has your child's hearing been checked recently? Yes/No Results: ____________________

Any concerns with hearing?

____

____

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Academic History

Please check all that apply to your child:

- ☐ Does well in school
  Does well in the area of: ___________________
- ☐ Is challenged by school
  Average grades: **A B C D F**
- ☐ Is in a self-contained classroom
- ☐ Is receiving school-based services.
  List services: ___________________

List any academic concerns you have:

____

____

List any specific teacher concerns:

____

____

Behavior/Social History

Please check all that apply to your child:

- ☐ Is social and engaging
- ☐ Makes good eye-contact with adults and peers
- ☐ Is well behaved
- ☐ Pays attention
- ☐ Listens well
- ☐ Follows directions well _____ 1 step
  _____ 2 step
- ☐ Plays well with other children
- ☐ Is easy going
- ☐ Does well with change
- ☐ Understands safety
- ☐ Takes turns with peers
- ☐ Recalls and tells about everyday events
- ☐ Maintains topic
- ☐ Is aggressive
- ☐ Is oppositional
- ☐ Does not like new places/people
- ☐ Does not like crowds
- ☐ Has difficulty with transitions
- ☐ Prefers to play alone
- ☐ Has difficulty paying attention
- ☐ Has difficulty listening
- ☐ Is very busy and active
- ☐ Poor coping skills
- ☐ Unable to self-calm
- ☐ Extremely sensitive to criticism
- ☐ Quickly escalates without apparent cause
- ☐ Has tantrums

Please list any behavioral or social concerns:

____

____

What are some of your child's favorite toys/interests?

____

____

____

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Evaluation & Therapy Services

Please list any previous therapy evaluations complete and recommendations:

____

____

____

____

Please list any previous psychological/neurophysological/psych-educational evaluations completed and recommendations:

____

____

____

____

Authorization for Treatment

My signature below is confirmation that I have informed Capstone Physical Therapy of all necessary information and have answered all questions truthfully and to the best of my ability. I authorize the therapists of Capstone Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment.

______________________________ ______________

Parent Signature Date

Insurance Information • Please present your insurance card to the front desk for scanning.

Primary Insurance ______________________ Subscribers Name ______________________

DOB ___/___/___ ID Number ______________________ Group Number ______________________

Secondary Insurance ______________________ Subscribers Name ______________________

DOB ___/___/___ ID Number ______________________ Group Number ______________________

I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original. If appointments are cancelled with less than 24 hour notice there is a $30 cancellation fee that will be the patients responsibility.

______________________________ ______________

Parent Signature Date