



PEDIATRIC THERAPY INTAKE

CHRISTUS Good Shepherd Health System 700 E. Marshall Ave., Longview, Texas 75601

Date: _____

WELCOME TO OUR CLINIC. To assist in your care, please fill out or circle the answers as best you can.

NAME: _____ DOB: _____ AGE: _____ Sex: ☐ Male ☐ Female

My child's primary language is: _____ Other languages child is exposed to: _____

My child primarily communicates by (circle best choice): **Verbalizations** **Gestures** **Grunts** **Points**

What concerns do you have: _____

What is your goal for your child: _____

Has your child received therapy previously? ☐ YES ☐ NO

WHEN, WHERE, HOW LONG, & type of THERAPY: _____

MEDICAL HISTORY

Has your child ever had any of the following?

- | | | |
|---|--|--|
| ☐ ADD/ADHD | ☐ Diarrhea | ☐ Periventricular |
| ☐ Allergies | ☐ Ear Infections (How Many? _____) | ☐ Psoriasis/Eczema |
| ☐ Anoxic Brain Injury | ☐ Fractures | ☐ Pulmonary Embolism/Blood Clots/ DVT |
| ☐ Anxiety/Depression/ Bipolar/ Schizophrenia/Oppositional Defiant Disorder | ☐ GERD/Reflux | ☐ Pneumonia |
| ☐ Arteriovenous malformation (AVM) | ☐ Head Injury | ☐ Seizures/Epilepsy |
| ☐ Arthritis: OA/RA/Deg. Joint | ☐ Hearing Loss | ☐ Sensory Processing Disorder |
| ☐ Asthma/respiratory problems | ☐ Hepatitis | ☐ Shunts |
| ☐ Autism | ☐ High blood pressure | ☐ Sleeping Difficulties/Disorder |
| ☐ Baclofen Pump | ☐ Hip subluxation | ☐ Stimulator |
| ☐ Cancer, if yes, what kind _____ | ☐ Hydrocele | ☐ Systemic Lupus Erythematosus |
| ☐ Cerebral Palsy | ☐ Incontinence | ☐ Thumb/Finger Sucking Habit |
| ☐ Chemical Dependency | ☐ Kidney Disease | ☐ Torticollis |
| ☐ Colic | ☐ Laryngomalacia | ☐ Traumatic Brain Injury (TBI) |
| ☐ Constipation | ☐ Leukomalacia | ☐ Tube Feeding |
| ☐ Down Syndrome | ☐ MRSA / Cdiff / VRE / HIV | ☐ Tubes in ears |
| ☐ Heart Problems: CHF/CAD | ☐ Multiple Sclerosis | ☐ Tuberculosis |
| ☐ Stroke/CVA / TIAs | ☐ Muscular Dystrophy | ☐ Vagal Nerve |
| ☐ Diabetes | ☐ Osteoporosis | ☐ Vision Problems |
| | ☐ Pacemaker | |
| | ☐ Peripheral Neuropathy/Peripheral Vascular Disease | |

Other medical conditions: _____

Orthopedic conditions: _____

Surgical History: _____

Allergies (medication, food, etc.): _____

Is your child currently taking any medications? ☐ NO ☐ YES (If yes, please complete Medication List)

BIRTH HISTORY

Birth weight _____ Birth height _____

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- Pregnancy** ☐ **Without Complications** ☐ **With Complications** (if with checked, select choices below)
- | | | | |
|--|--|--|---|
| ☐ Eclampsia | ☐ Polyhydramnios | ☐ HIV | ☐ Substance exposure |
| ☐ Exposure to opioids/drugs/other pharmaceuticals | ☐ Cytomegalovirus (CMV) | ☐ Strep B | ☐ Toxemia |
| ☐ Gestational Diabetes | ☐ Herpes | ☐ Pre-Eclampsia | ☐ Other: |
| ☐ Multiple births | ☐ Foster | ☐ Premature labor | |

Was pregnancy full term? ☐ Yes ☐ No If NO, then how many weeks gestation? _____

Additional Comments about pregnancy: _____

- Delivery** ☐ **Without Complications** ☐ **With Complications** (if with checked, select choices below)
- | | | |
|--|---|---|
| ☐ Abruptio placenta | ☐ Non-progressive/unproductive labor | ☐ Umbilical cord wrapped around neck |
| ☐ Breech presentation | ☐ Occiput posterior position (face up) | ☐ Premature rupture of membranes |
| ☐ Low birth weight | ☐ Placental Previa | ☐ Other: |
| ☐ Negative vacuum | | |

What was the method of delivery? ☐ Vaginal ☐ Planned C-Section ☐ Emergency C-Section ☐ Breech

If C-Section, then what reason? _____

Additional Comments about delivery: _____

- Following Birth** ☐ **Without Complications** ☐ **With Complications** (if with checked, select choices below)
- | | | |
|---|---|--|
| ☐ Anemia of Prematurity | ☐ Hyperbilirubinemia | ☐ Positive dependency |
| ☐ Bronchopulmonary Dysplasia (BPD) | ☐ Intrauterine Growth Retardation (IUGR) | ☐ Respiratory Distress Syndrome |
| ☐ Cleft lip | ☐ Jaundice treated by light therapy and/or blanket | ☐ Respiratory Stridor |
| ☐ Cleft Palate | ☐ Meconium Aspiration | ☐ Respiratory Syncytial Virus (RSV) |
| ☐ Club Foot | ☐ Necrotizing Enterocolitis (NEC) | ☐ Retinopathy of Prematurity (ROP) |
| ☐ Cytomegalovirus | ☐ Neonatal hypoxia | ☐ Thrombocytopenia (low platelet count) |
| ☐ ECMO | ☐ Oxygen required | ☐ Ventilator Dependency |
| ☐ Failure to Thrive | ☐ PDA | ☐ VP Shunt |
| ☐ Feeding complications | | ☐ Other |

Length of child's hospital stay at birth: _____

Additional Comments about following birth: _____

How was your child initially fed, and until what age? ☐ Breast ☐ Bottle Age: _____

FEEDING

Does your baby/child let you know when he/she is hungry?

☐ Yes ☐ No

Do you think your baby/child eats enough?

☐ Yes ☐ No

How many minutes does it usually take to feed your baby/child?

☐ <5 ☐ 5-30 ☐ >30

Do you have to do anything special to help your baby/child eat?

☐ Yes ☐ No

Does your baby/child let you know when he/she is full?

☐ Yes ☐ No

Based on the questions above, do you have concerns about your baby/child's feeding?

☐ Yes ☐ No

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How many foods does your child currently eat?

☐ <5☐ 5-10☐ >10

If < 5, list foods: _____

HOME ENVIRONMENT**Child Lives with (please select all that apply):**

- | | |
|---------------------------------------|---|
| ☐ Birth mother | ☐ Siblings (if yes, ages) |
| ☐ Birth father | Ages: _____ |
| ☐ Adoptive mother | |
| ☐ Adoptive father | |
| ☐ Step-mother | ☐ Other Relatives (If yes, specify) |
| ☐ Step-father | _____ |
| ☐ Grandmother | |
| ☐ Grandfather | ☐ Legal Guardian (If yes, specify) |
| | _____ |

Is there any history of speech, language, or hearing difficulties, delays, or impairments in the family or extended family?

☐ YES ☐ NO If YES, please describe: _____Is your child adopted? ☐ Yes ☐ No If YES, age of adoption: _____

Additional Details about adoption: _____

My child spends most of the day(s) at: _____

When at home, my child usually:

- | | |
|---|--|
| ☐ Watches television | ☐ Play independently |
| ☐ Plays with adult | ☐ Other: |
| ☐ Plays with other children | |

Type of Home:

- | | |
|--|--|
| ☐ Single level | ☐ Assisted Living Facility |
| ☐ Two level | ☐ Foster Care |
| ☐ Ground Floor Apartment | ☐ Group Home |
| ☐ Upper Level Apartment | ☐ Other: |

Accessibility: ☐ Stairs into Home: # of steps _____ ☐ Handrail ☐ Ramp**Equipment presently used:**

- | | | |
|-----------------------------------|---|---|
| ☐ Braces | ☐ Stander | ☐ Wheelchair: Power or Manual |
| ☐ Hand splint | ☐ Track System | ☐ Speech Generating Device |
| ☐ Hoyer Lift | ☐ Weighted vest/blanket | ☐ Other: |
| | | ☐ |

Describe any home program that is currently performed: _____

List any community groups or sports activities that child is involved in: _____



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SCHOOL: _____

Grade: _____

Is your child receiving Therapy from the school? ☐ Yes ☐ No

If yes: Last IEP Date: _____

Current goals:

Occupational: _____

Physical: _____

Speech: _____

Is your child in a Special Education program? ☐ Yes ☐ No

Does your child receive any classroom modifications? ☐ Yes ☐ No

If YES, please explain: _____

Has your child had a psychological or neuropsychological evaluation completed?: ☐ Yes ☐ No

Has your child received any of the following services? If YES, please give more information (type, status, how often, where, etc.)

- | | |
|--|---|
| ☐ ABA | ☐ EI Services |
| ☐ Assistive Technology | ☐ Intensive Suite Therapy Vision |
| ☐ Audiology | ☐ Nutrition |
| ☐ Behavior Therapy | ☐ Social Therapy |
| ☐ Developmental History | ☐ Other |

INFORMATION ABOUT CHILD

Description of child:				
☐ Active	☐ Cautious	☐ Fearful	☐ Motivated	☐ Shy
☐ Affectionate	☐ Demanding	☐ Fearless	☐ Passive	☐ Stubborn
☐ Aggressive	☐ Difficult to comfort	☐ Fussy	☐ Persistent	☐ Withdrawn
☐ Calm	☐ Distractable	☐ Insecure	☐ Playful	☐ Other:

Favorite toys/play activities: _____

Do you have any safety concerns for your child? ☐ Yes ☐ No If YES, please explain: _____

Is your child able to follow simple commands? ☐ Yes ☐ No Example: _____

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OCCUPATIONAL THERAPY

Check each item that the patient can do and then write the age they began the task.

Does your child?

Began at age:

- ☐ Buttoning pants/shirt
- ☐ Fasten buttons
- ☐ Feed themselves with a utensil
- ☐ Fully Toilet Trained
- ☐ Have a hand dominance
- ☐ Imitate tool use (e.g. brushing hair, using a toothbrush)
- ☐ Match shapes
- ☐ Play with items using both hands
- ☐ Point or poke items (isolate their fingers)
- ☐ Self-bathing
- ☐ Self-dressing
- ☐ Stack blocks
- ☐ Take on/off their socks and shoes
- ☐ Throw/Roll a ball
- ☐ Tying shoes
- ☐ Use scissors
- ☐ Understand the difference of right from left
- ☐ Write their name

If yes, which hand? _____

Sensory Processing & Regulation (please select all that apply):

- ☐ Stumbles or falls frequently
- ☐ Appears awkward or less coordinated
- ☐ Has difficulty figuring out how to move body or takes more time with movements
- ☐ Has poor sense of body space, runs into things
- ☐ Seeks support for posture (e.g. leans on furniture, walls, or people, holds head)
- ☐ Demonstrates stiff or rigid movement patterns
- ☐ Fatigues quickly
- ☐ Has self-abusive behaviors
- ☐ Resists certain tasks or environments
- ☐ Uses lots of pressure when touching someone or holding object
- ☐ Resists certain movements (e.g. bouncing, swinging, upside down)
- ☐ Spins things or self
- ☐ Is sensitive to lights, sounds, or noise
- ☐ Does not tolerate certain textures (e.g. clothing, surfaces, foods)
- ☐ Resists touch
- ☐ Seeks out (craves) visually stimulating objects
- ☐ Does not allow brushing of teeth
- ☐ Bangs on surface, bangs/hits head
- ☐ Flaps hands
- ☐ Frequently puts items in mouth
- ☐ Other:



PHYSICAL THERAPY

Began at age:

- Hold head up alone
- Hold head upright during bouncing on your knee
- Lay on tummy propped on elbows with head upright
- Bring both hands/feet to mouth while laying on back
- Roll over without assistance
- Move from lying on back to sitting without help
- Sit alone without support
- Army crawl on tummy alone
- Crawl on hands and knees alone
- Pulls self to standing at support surface
- Walk with support from caregiver
- Crawl forward and backwards down steps
- Stand unsupported
- Walk without assistance
- Overhead throw a ball forward while standing
- Maintain squat position during play
- Kick a ball forward without losing balance
- Walk up five steps with support from rail or caregiver
- Walk backwards while pulling toy
- Jump in place with both feet together
- Catch ball with both hands
- Stand on 1 foot
- Jumps forward with 2-foot take off
- Walks up and down steps without support
- Runs without falling
- Performs single leg hopping

[illegible]

How does your child get around the house?

Does your child demonstrate toe walking? ☐ With Shoes ☐ Without Shoes ☐ No, does not

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SPEECH THERAPY

HEARING:

Has your child ever had his/her hearing checked? ☐ Yes ☐ No When/Where: _____

Do you have concerns with your child's hearing? ☐ Yes ☐ No

If YES, please explain: _____

Circle the sounds your child says correctly:

b d f h l m n p r t v w y z sh

g k ch th br gr sl str thr tr s
a (cat) e (pet) i (hit) o (hot) u (cup) j (jelly) a (cake) e (tree) o (go) u (blue)

List any sounds or words that are difficult for your child: _____

What was your child's first word and at what age? Word: _____ Age: _____

About how many words does your child produce?

If less than 10, please list words:

1.	4.	7.
2.	5.	8.
3.	6.	9.

My child says (If less than 3 per category, please list):

- | | |
|--|--|
| ☐ family names | ☐ daily routines (night-night, bath, eat) |
| ☐ animals (pet's name, dog, cat, etc) | ☐ body parts |
| ☐ food (juice, water, milk, cookie, chip) | ☐ clothing |
| ☐ toys | ☐ other: _____ |

My child's speech is understood by:

(Please check those that apply & write an estimate for the percentage of speech that is understood by those people.)

- | | |
|--|--|
| ☐ family members living in house _____% | ☐ other family members _____% |
| ☐ care providers _____% | ☐ familiar people _____% |
| ☐ unfamiliar people _____% | |

Other Information about Child:

Does your child have problems making eye contact? ☐ Yes ☐ No

Does your child have problems with expressing his/her thoughts? ☐ Yes ☐ No

Do you have any feeding/eating concerns for your child? ☐ Yes ☐ No

If yes, Explain: _____

How much screen time (tablet, phones, computer, TV, etc.) does your child have per day, on average? _____

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My child follows my directions when I:

- ☐ use gestures (hold out my hands to pick him or her up, wave bye-bye)
- ☐ say words paired with gestures (say “look” while pointing)
- ☐ say words and simple phrases (stop, come here)
- ☐ say one step directions (give me a hug, eat your cookie)
- ☐ say two step directions (get your blanket and lay down; find your socks and bring them here)

My child communicates with me by:

- ☐ using different vocalizations to express self (screams, cries-has different cries for different emotions)
- ☐ gestures (lifts arms to be picked up)
- ☐ says specific sounds for things (“uh” for up; “ma” for momma; “di” for drink)
- ☐ speaks in phrases (more cracker, no bath, get down)
- ☐ using physical actions (pulls you to refrigerator, puts toy in hand)
- ☐ points to things he or she wants
- ☐ says specific words for things (no, bye, eat)
- ☐ speaks in sentences (I want cookie.; I go outside.)
- ☐ other: _____

When playing with other children, my child sometimes PLAYS:

- ☐ beside other children without sharing his or her toys
- ☐ with other children by telling them what to do
- ☐ with other children by following what they do or say
- ☐ with other children by sharing toys and talking
- ☐ My child does not play with other children

When playing, my child:

- ☐ shakes and bangs objects (ex: rattle, bangs a wooden spoon)
- ☐ plays simple games with me (ex: peek-a-boo, pat-a-cake)
- ☐ plays with toys appropriately (ex: rolls ball, stacks blocks)
- ☐ uses toys in pretend play (ex: uses blocks as ice in cups, uses a pot a drum)
- ☐ plays with two or more toys together (ex: stacks two or more blocks, pushes a car into stacked blocks)
- ☐ acts out familiar situations (ex: dresses a doll, pretends to drink from a cup)
- ☐ acts out unfamiliar situations (ex: walks a stuffed animal through the jungle)

My child enjoys getting attention. My child:

- ☐ smiles when I talk to him or her
- ☐ “talks” when I talk to him or her (coos, babbles, etc)
- ☐ takes turns talking with me using sounds or words
- ☐ invites me to play with him or her (purposefully drops a toy to be picked up; brings me toy, etc)

My child pays attention to what is happening around him or her. My child:

- ☐ reacts to sound (ex: startles when a door is slammed)
- ☐ looks up from what he/she is doing when I call his/her name
- ☐ looks toward where I am pointing when I say to look at _____
- ☐ looks at people who are talking
- ☐ looks for food that has fallen from highchair
- ☐ other: _____



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GOALS

Setting goals is necessary to help with your child's treatment and justify medical need. Your input is essential to help set your child's goals.

Please list any activities that your child currently is unable to do, but you think they should be able to:

Was he/she able to do any of these before? If yes, please list: _____

What have you done to help correct these? _____

What has been helpful? _____

What has not been helpful? _____

Is your child aware of his/her difficulties? _____

If yes, how does he or she feel about it? _____

Please state your goals for patient's therapy: _____

Additional comments: _____

Please list a good e-mail address below:

EMAIL: _____

We may send messages through e-mail ☐ Yes ☐ No

Signature Date Time

Printed name of Guardian completing Form