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Restored Hope Therapy Services, PLLC
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Child Intake Form / History

Today's Date __________

Client Name: ____________________________ Nickname: ____________

Date of Birth: ______________ Age: _________ ☐ Male ☐ Female

Diagnosis (if known): ____

Parent(s) / Guardians: ____

Address: ____

City, State, Zip: ____

Phone:___________________________ ☐ Cell ☐ Home ☐ Work ☐ Other

Email #1:____

Emergency Contact Name: _______________________________________

Emergency Contact Relationship to Child: ___________________________

Emergency Contact (Information): __________________________________

Client's Physician: ____

Physician Phone Number: ____

Physician Address: ____

Other Physicians / Specialists Involved In Care:

Referring Physician: _______________ Phone Number _________________

Physician Address: ____

Secondary Physician: _______________ Phone Number _________________

Physician Address: ____

INSURANCE

Person Responsible for Account:

Relationship to Client:

Date of Birth:

Copay Amount:

Insurance Company:

Subscriber I.D. #: Group #:

Family Background

Parent 1 Name: _________________________ Age: ______
Occupation: ___________________________ Education Level: ________
Parent 2 Name: _________________________ Age: ______
Occupation: ___________________________ Education Level: ________
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

What adults does the child live with? Check all that apply:

☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)
☐Grandparent(s) ☐Both Parents ☐Parent 1 Only
☐Parent 2 Only ☐Other: ____

Does the child have siblings or are there other siblings in the home?
Child 1 Name: ___________ Age: __ Sex: __ Delay Issues:__________________
Child 2 Name: ___________ Age: __ Sex: __ Delay Issues:__________________
Child 3 Name: ___________ Age: __ Sex: __ Delay Issues:__________________
Child 4 Name: ___________ Age: __ Sex: __ Delay Issues:__________________
Child 5 Name: ___________ Age: __ Sex: __ Delay Issues:__________________

Language(s) spoken in the home: ______________________________________
Who speaks the other language(s)? ____________________________________
Describe the child's use/understanding of the language(s): __________________
____

Is there anything additional you would like to share about the family / home environment? ____

____

____

Evaluation

Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons:
____

____

____

____

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Has the child had a previous occupational therapy or feeding evaluation / treatment? ☐Yes ☐No By whom: ___________________________
When: ____

Describe the results: ____

____

At what age did you first notice the problem? ____________________________

How do the child's difficulties impact the family? ___________________________

____

____

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:
____

____

____

____

____

____

____

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐Yes ☐No
Describe: ____
2. Was there any stress during the pregnancy? ☐Yes ☐No
Describe: ____
3. Were there any complications during labor or delivery? ☐Yes ☐No
Describe: ____
4. What was the mother's age at the time of delivery? _____ years

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Child's Health:

1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)
2. The child was ______ lbs ____oz and ________ inches at birth
3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section
4. Please describe any complications or concerns during labor or delivery:

____

____

Check and describe all that apply:

☐ Adenoidectomy Describe: ________________________________

☐ Asthma Describe: ________________________________

☐ Behavior Issues Describe: ________________________________

☐ Brain injury Describe: ________________________________

☐ Breathing problems Describe: ________________________________

☐ Cardiac issues Describe: ________________________________

☐ Chicken pox Describe: ________________________________

☐ Diabetes Describe: ________________________________

☐ Ear infections Describe: ________________________________

☐ Ear tubes Describe: ________________________________

☐ Encephalitis Describe: ________________________________

☐ Frequent colds Describe: ________________________________

☐ High fever Describe: ________________________________

☐ Measles Describe: ________________________________

☐ Meningitis Describe: ________________________________

☐ Mumps Describe: ________________________________

☐ Seizures Describe: ________________________________

☐ Sensory issues Describe: ________________________________

☐ Sleep issues Describe: ________________________________

☐ Tongue tie Describe: ________________________________

☐ Tonsillitis Describe: ________________________________

☐ Tonsillectomy Describe:_________________________________

☐ Traumatic brain injury Describe: _________________________________

☐ Vision issues Describe: ________________________________

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Has the child ever had surgery? ☐ Yes ☐ No
Please describe: ____
____
____

Has the child ever been hospitalized: ☐ Yes ☐ No
Please describe: ____
____
____

Has the child ever been in a serious accident? ☐ Yes ☐ No
Please describe: ____
____
____

Does the child have a chronic illness? If so, please describe: ____________
____
____

Is the child currently on any medications? If so, please list medication name and reason for medication:
Medication 1: ____
Medication 2: ____
Medication 3: ____
Medication 4: ____

Does the child have any known allergies? ☐ Yes ☐ No
Describe: ____
____
____

Does the child currently use any equipment? (communication device, walker, etc.) Describe: ____
____
____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.
☐Developmental Pediatrician ____

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☐Neurologist ____

☐PT ____

☐OT ____

☐SLP ____

☐Behavioral Therapist ____

☐Educational Consultant ____

☐Psychologist / Psychiatrist ____

☐Vision Therapist ____

☐Other: ____

Developmental History

At what age did the child do the following:

Sit alone: ____________ Crawl: ___________________

Stood Up: ____________ Walk: ________________

Made Sounds: ___________ First Word: __________

Combined Words: ___________ Sentences: _________________

Fed Self: ________________ Understood by Others________

Toilet Trained: ______________ Dressed Self: ________________

Educational History

Is the child currently enrolled in daycare/ school: ☐ Yes ☐ No

What is the name of the program? ____

What day(s) do they attend? ____

What are your goals for the child over the next 6 months? _______________

____

____

____

Person filling out the form: ____

Relationship to the child: ____