



## Client Intake Form

Please fill out this form in full and return it to the office at your earliest convenience.  
Thank you for your cooperation.

Today's Date \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number(s): \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Pediatrician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

### PARENT INFORMATION

Mother/Guardian \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Place of employment: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Father/ Guardian \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
E-mail address \_\_\_\_\_  
How did you hear of us? \_\_\_\_\_

### DIAGNOSIS INFORMATION

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_  
Problem Areas: \_\_\_\_\_  
Is your child receiving other therapies? Yes/No If Yes, which ones? \_\_\_\_\_  
\_\_\_\_\_

### INSURANCE INFORMATION

#### Primary Insurance Information

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Relationship to Insured: \_\_\_\_\_  
Child's Case manager \_\_\_\_\_

#### Secondary Insurance Information

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Relationship to Insured: \_\_\_\_\_

### BIRTH HISTORY

Length of Pregnancy: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Chronological Age: \_\_\_\_\_  
Problems during pregnancy? \_\_\_\_\_

Was the child hospitalized at birth? \_\_\_\_\_  
Has the child been hospitalized since birth? \_\_\_\_\_  
Has vision been tested? Yes No If yes, by whom? \_\_\_\_\_  
Has hearing been tested? Yes No If yes, by whom? \_\_\_\_\_  
Results of tests? \_\_\_\_\_

**MEDICAL HISTORY**

Childhood Illnesses (Please Check)  
Allergies \_\_\_\_\_ Measles \_\_\_\_\_ Asthma \_\_\_\_\_  
Pneumonia \_\_\_\_\_ Ear Infections \_\_\_\_\_ Mumps \_\_\_\_\_  
Tubes in Ears \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Seizures \_\_\_\_\_  
Any other medical information you feel we should be aware of? \_\_\_\_\_

Has your child seen a neurologist? Yes No If yes, by whom? \_\_\_\_\_  
Results: \_\_\_\_\_  
Please list any medications taken regularly: \_\_\_\_\_

Any allergies? \_\_\_\_\_

**DEVELOPMENTAL MILESTONES**

Rolled over \_\_\_\_\_ Crawled \_\_\_\_\_ Sat up \_\_\_\_\_  
Stand \_\_\_\_\_ Walked \_\_\_\_\_ First Word \_\_\_\_\_

At your child's present age, how do you feel his/her speech and language skills have developed? \_\_\_\_\_  
At what age did he/she begin helping dress? \_\_\_\_\_  
Describe his/her dressing routine: \_\_\_\_\_

Can your child manipulate fasteners? \_\_\_\_\_  
Tie his/her own shoes? \_\_\_\_\_  
Describe the child's sleep patterns: \_\_\_\_\_

Did the child enjoy snuggling or being held as an infant? \_\_\_\_\_  
What are the child's current eating habits? \_\_\_\_\_

Any feeding problems during infancy? \_\_\_\_\_

Does the child drink from a bottle or cup? \_\_\_\_\_  
What diet is your child presently on (baby food, puree, chopped, etc)? \_\_\_\_\_

Does child feed self? \_\_\_\_\_  
At what age did self-feeding begin? \_\_\_\_\_  
What food does your child especially like? \_\_\_\_\_ Dislike: \_\_\_\_\_  
Is the child toilet trained? Yes No If yes, at what age? \_\_\_\_\_  
How long does the child play alone? \_\_\_\_\_

**EDUCATIONAL HISTORY**

What school does your child attend? \_\_\_\_\_  
Does your child like school? \_\_\_\_\_  
Check any areas of difficulty or concerns for your child.  
Reading \_\_\_\_\_ Math \_\_\_\_\_ Attention \_\_\_\_\_ Writing \_\_\_\_\_  
Socialization \_\_\_\_\_ Behavior \_\_\_\_\_ Phys. Ed \_\_\_\_\_ Playground \_\_\_\_\_  
Do you feel your child can organize work adequately? \_\_\_\_\_

