Therapy Intake Form
Upwards Pediatric Therapy, LLC

Today's Date: __________ Completed by: ______________________________
(i.e., mom, dad, guardian . . .)

Last Name: ____________________________ Child's Name: ______________________________

Address: ______________________________________ DOB: _________ Age: __________
(month/day/year)

City: ___________________ State: ______ Zip: _________ Check one Female: _____ Male: _____

E-mail: ____ Ethnicity: __________________________

Contact Information:

Mother's Name: ____________________________ Father's Name: ______________________________

Address:___________________________________ Address: __________________________________
(If different then above address) (If different then above address)

____ ____

Home Phone: ___________________________ Home Phone: _______________________________

Cell Phone: _____________________________ Cell Phone: __________________________________

Emergency Contact:

Name: ____________________________ Relationship: ________________ Phone: ________________

School: ____ Grade: ________________

Teacher's Name: ____________________ Type of Classroom: _____________________ (i.e. mainstream, resource . . .)

Child's Health Care Providers: (Include Primary Care Physician):

Name: _________________________ Profession: __________________ Phone: ________________

Address: ____

Name: _________________________ Profession: __________________ Phone: ________________

Address: ____

Name: _________________________ Profession: __________________ Phone: ________________

Address: ____

Name: _________________________ Profession: __________________ Phone: ________________

Address: ____

Therapy Intake Form
Upwards Pediatric Therapy, LLC

A

Name: __________________________ Profession: ____________________ Phone: __________________

Address: ____

Family Members – Detailed Information

Father:	Age: ________	Occupation: _______________________________	Handedness: R L
Stepfather:	Age: ________	Occupation: _______________________________	Handedness: R L
Mother:	Age: ________	Occupation: _______________________________	Handedness: R L
Stepmother:	Age: ________	Occupation: _______________________________	Handedness: R L

Personality Profile:

What are your child's gifts/strengths?

What do you enjoy most about your child and family

What are the presenting problems for your child? (All categories below may not apply.)

Academic:

Activities of daily life (eg. Eating, dressing):

Relationships

Sensory:

Gross Motor:

Fine Motor:

Play:

Language

Other:

What kind of interests and activities does your child have? (Hobbies, sports, clubs?)

Please list them in order of preference beginning with the favorite activity:

Has your child been diagnosed with? (Please check all that apply):

___ ADD (Attention Deficit Disorder)

___ ADHD (Attention Deficit Hyperactivity Disorder)

___ Anxiety or Mood Disorder – (specify):

___ ASD (Autism Spectrum Disorder)

___ Cognitive Delay

___ APD

___ Dyslexia

___ Emotional Disorder – (specify):

___ Fragile X Syndrome

___ Learning Disabilities – (specify):

___ Sensory Processing Disorder or Sensory Integration Dysfunction

___ Tourette's Syndrome

___ Other – (specify):

Who provided the diagnosis?

Name: ____ Certification: ______________________________

Based on what criteria? (check)

___ Test Scores ___ Comprehensive Clinical Evaluation ___ Genetic Study ___ Other ________________

Medications:

List any medications your child has received in the past year

Medication: (Name)	Purpose:	When Taken:	Currently Taking:	
1. ________________________	_____________________	□ morning, □ mid day, □ night	yes	no
2. ________________________	_____________________	□ morning, □ mid day, □ night	yes	no
3.________________________	_____________________	□ morning, □ mid day, □ night	yes	no
4. ________________________	_____________________	□ morning, □ mid day, □ night	yes	no
5. ________________________	_____________________	□ morning, □ mid day, □ night	yes	no
6. ________________________	_____________________	□ morning, □ mid day, □ night	yes	no
7. ________________________	_____________________	□ morning, □ mid day, □ night	yes	no
8. ________________________	_____________________	□ morning, □ mid day, □ night	yes	no
9. ________________________	_____________________	□ morning, □ mid day, □ night	yes	no
10. _______________________	_____________________	□ morning, □ mid day, □ night	yes	no

Any vitamins or supplements:

Family Adaptation:

How would you describe your child's general adjustment at home? ___ Poor ___ Fair ___ Good ___ Excellent

Have there been any traumatic family events in the course of this child's development?

Have there been any major moves? (city to city, country to country)

Pregnancy: (If child is adopted, skip to adoption section)

What kind of experience was the pregnancy for both mother and father?

Mother: ____

Father: ____

Were there complications? □ Yes □ No

- Shock □ Yes □ No
- Severe stress □ Yes □ No
- Loss of a loved one □ Yes □ No
- Accident □ Yes □ No
- Health Problems □ Yes □ No (if yes specify) ____
- Bed Rest □ Yes □ No
- Multiples □ Yes □ No

Did the Mother?

- Smoke □ Yes □ No
- Consume Alcohol □ Yes □ No
- Take medications □ Yes □ No (if yes specify) ____
- Physically Exercise □ Yes □ No
- Have previous pregnancies with complications? □ Yes □ No

Labor and Delivery

Describe your experience during labor and delivery:

Induced □ Yes □ No

Length of Labor __________ hours

Premature __________ weeks

Forceps used □ Yes □ No High Forceps □ Yes □ No

Suction □ Yes □ No

Breech □ Yes □ No

Caesarean □ Yes □ No (if yes - reason) ____

Birth weight _____ lbs _____ oz

APGAR ratings _____________

Cried immediately □ Yes □ No

Required Oxygen □ Yes □ No

Jaundice □ Yes □ No

Birth Injuries □ Yes □ No (if yes - specify) ____

Did the newborn have immediate physical contact with the mother? □ Yes □ No

Was there a positive bonding experience between mother and newborn at birth? □ Yes □ No

Did mother experience any post-partum depression? □ Yes □ No

Adoption

Describe the circumstances surrounding the adoption:

More specifically:

Age of child when adopted: ______________

Adopted from (country): ____________________________________

Prior foster homes? □ Yes □ No

Physical appearance:____

Response to new home: ____

Is your child aware of his/her adoption? □ Yes □ No

Infancy & Toddlerhood

Going back to the first two years of the child's life, what type of baby was he/she? (feeding, sleeping, activity level)

More specifically:

Breastfed? □ Yes □ No (If Yes, how long) ______________________

Extended separation during first two years (over 3 days) □ Yes □ No

Thumb sucking □ Yes □ No (Until what age?) ______________________

Pacifier □ Yes □ No (Until what age?) ______________________

Feeding problems □ Yes □ No (specify) ____

Sleeping problems □ Yes □ No (specify) ____

Colic or "fussy baby" □ Yes □ No

Prefer certain positions □ Yes □ No (specify) ____

Dislike lying on stomach □ Yes □ No

Dislike lying on back □ Yes □ No

Able to self soothe □ Yes □ No

On a regular schedule □ Yes □ No

Enjoyed bouncing □ Yes □ No

Enjoyed car rides □ Yes □ No

Enjoyed the infant swing □ Yes □ No

Childhood Illnesses / Problems

Ear Infections □ None □ Couple (1-2)□ Several (3-5) □ Many (5+)

Tubes in ears □ No □ Yes Date: ______________

Respiratory problems □ No □ Yes Date:______________

High fever (over 104) □ No □ Yes Date: ______________

Meningitis □ No □ Yes Date: ______________

Adenoid problems □ No □ Yes Date: ______________

Frequent colds □ No □ Yes

Strep Throat □ No □ Yes Date: ______________

Allergies □ No □ Yes To what?: ______________

Asthma □ No □ Yes (specify) ____

Bronchitis □ No □ Yes (specify) ____

Skin problems	□ No	□ Yes	(specify) ____________
Gastro-Intestinal Problems	□ No	□ Yes	(specify) ____________
Seizures	□ No	□ Yes	(specify) ____________
Epilepsy	□ No	□ Yes	(specify) ____________
Nightmares	□ No	□ Yes	(specify) ____________
Sleep difficulties	□ No	□ Yes	(specify) ____________
Bedwetting	□ No	□ Yes	(specify) ____________
Nail Biting	□ No	□ Yes	(specify) ____________
Broken limbs	□ No	□ Yes	(specify) ____________
Car sickness	□ No	□ Yes	(specify) ____________
Hospitalized	□ No	□ Yes	(reasons) ____________
Serious Accident/Injury	□ No	□ Yes	(specify) ____________

Any other medical illnesses or conditions which have been diagnosed?

Nutrition (Check all that are appropriate)

A. Gastro intestinal problems

- Colic
- Tummy pains/gassy
- Unusual bowel patterns
- Recurrent constipation
- Diarrhea

B. Skin Problems:

- Eczema
- Dry patches on face or arms
- Nutmeg grater (little tiny bumps)
- Dermatitis
- Blue circles under eyes
- Anything else?

C. Ear Nose & Throat Problems

Mouth ulcers

Bad breath

Tonsillitis

Earache

Sinusitis

Persistent runny nose

Snoring

Mouth breathing

Hay fever

D. Asthma - Induced by:

Exercise

Infection

Dust

Mold

Animals'

Food

Anything else?

Does your child suffer from excessive thirst? Yes No

Do his/her symptoms get worse if he/she has more than a 2-3 hour interval without eating? Yes No

Describe:

Are there any particular foods which alter his/her behavior? Yes No

If yes, please specify:

What does your child typically eat?

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Vitamins/Supplements:

Will your child eat (check all that apply):

___ Apples

___ Bacon

___ Bagel

___ Banana

___ Carrots

___ Cereal with milk

___ Cereal without milk

___ Cheese

___ Chicken - breaded

___ Chicken - breast

___ Crackers

___ Cucumber

___ Eggs

___ French toast

___ Fries

___ Grapes

___ Grilled Cheese

___ Ground Beef

___ Ham

___ Juice

___ Kiwi

___ Milk

___ Oatmeal

___ Oranges

___ Pancakes

___ Pasta

___ Pear

___ Peas

___ Pepper slices

___ Pork

___ Potato

___ Rice

___ Salad

___ Sandwich

___ Sausage

___ Steak

___ Sweet Potato

___ Toast/bread with butter/jelly

___ Turkey

___ Waffles

___ Water

___ Yogurt

Foods he/she is allergic to:

Developmental Milestones (Give approximate ages if you can remember or comment on anything unusual)

Babbling	□ Yes □ No	Age: ____________
Rolled Over	□ Yes □ No	Age: ____________
Crawled (hands and knees)	□ Yes □ No	Age: ____________
Walked	□ Yes □ No	Age: ____________
Sit Alone	□ Yes □ No	Age: ____________
Said words	□ Yes □ No	Age: ____________
Ate solid foods	□ Yes □ No	Age: ____________
Say sentences	□ Yes □ No	Age: ____________
Drink from a cup	□ Yes □ No	Age: ____________

Drink from a straw	Yes	No	Age:
Go up stairs (crawling)	Yes	No	Age:
Go up stairs (walking)	Yes	No	Age:
Go down stairs (crawling)	Yes	No	Age:
Go down stairs (walking)	Yes	No	Age:

Was there tummy time? □ Yes □ No If yes, how often? ___________

Did he/she use a walker? □ Yes □ No Age: ___________ If yes, how often? ___________

Visual Development

Has your child experienced any problems with his/her eyesight or vision? Yes No

Describe:

Are there any current problems of which you are aware? Yes No

When was the last time his/her eyesight was tested:

Any trouble reading? Yes No

Auditory Development

Has your child experienced any problems with his/her hearing? (operations, infections, tubes)

Ear infections:

How many between 0-12 months?

How many between 13-24 months?

How was it treated?

Are there any current hearing problems of which you are aware?

Describe:

Speech & Language Development

A. Expressive Language

How would you describe your child's speech and language development? (normal, delayed, advanced)

Did your child begin speaking in single words, then two, then a sentence? □ Yes □ No

Did your child not talk for a long while and then all of a sudden speak in complete sentences? □ Yes □ No

Do you or others have difficulty understanding what the child says? □ Yes □ No

First words? ____ What age? ____

Describe any speech related problems?

Expressive Listening (This is listening that is directed within. We use it to control our voice when we speak and sing)

a. Flat and monotonous voice
b. Hesitant speech
c. Weak vocabulary
d. Poor sentence structure
e. Inability to sing in tune
f. Confusion or reversal of letters
g. Poor reading comprehension
h. Poor reading aloud
i. Poor spelling

Behavioral and Social Adjustment

a. Low tolerance of frustration
b. Poor self image
c. Difficulty making friends
d. Tendency to withdraw, avoid others
e. Low motivation no interest in school work
f. Immaturity
g. Irritability
h. Shyness

Sensory & Motor Development (please check any that apply)

A. My child seems to be overly sensitive to sensory experiences more so than most people

___ auditory ___ tactile ___ visual ___ movement ___ taste ___ smell

B. My child doesn't seem to react to sensory experiences as readily as most people

___ auditory ___ tactile ___ visual ___ movement ___ taste ___ smell

C. My child actively seeks out sensory experiences more so than most people

___ auditory ___ tactile ___ visual ___ movement ___ taste ___ smell

D. My child has difficulty differentiating sensory experience ___

(ex. Confuse sounds, can't find objects in drawer without looking, bumps into things . . .)

Describe:

My child has trouble learning new movement □ Yes □ No

My child tends to be clumsy and has balance and coordination problems □ Yes □ No

Does your child participate in sports? □ Yes □ No

Describe:

Activity Level:

Child tends to be tired by the end of the day? □ Yes □ No

Child appears hyperactive? □ Yes □ No

Type of movement most sought:

__ Jumping

__ Hanging upside down

__ Rocking forward/back and side to side

__ spins twirls

__ runs around the house

Previous Testing and Treatments

Has your child had any previous Assessments or Treatment?

Please attach all relevant reports.

Medical:

Assessment: □ Yes □ No Place: ________________________ Date: ____________

Treatment: □ Yes □ No Place: ________________________ Date: ____________

Audiological:

Assessment: □ Yes □ No Place: ______________________ Date: ___________

Treatment: □ Yes □ No Place: ______________________ Date: ___________

Speech:

Assessment: □ Yes □ No Place: ______________________ Date: ___________

Treatment: □ Yes □ No Place: ______________________ Date: ___________

Educational:

Assessment: □ Yes □ No Place: ______________________ Date: ___________

Treatment: □ Yes □ No Place: ______________________ Date: ___________

Psychological

Assessment: □ Yes □ No Place: ______________________ Date: ___________

Treatment: □ Yes □ No Place: ______________________ Date: ___________

Occupational Therapy:

Assessment: □ Yes □ No Place: ______________________ Date: ___________

Treatment: □ Yes □ No Place: ______________________ Date: ___________

Physical Therapy:

Assessment: □ Yes □ No Place: ______________________ Date: ___________

Treatment: □ Yes □ No Place: ______________________ Date: ___________

Other: ____________________

Assessment: □ Yes □ No Place: ______________________ Date: ___________

Treatment: □ Yes □ No Place: ______________________ Date: ___________

Comments:

Education

How did your child adapt to the first day(s) at school or pre-school:

□ Mostly positive □ Mixed □ Mostly negative

How old was he/she? ________ How much time did he/she attend per week? __________________

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience:

Initial school adjustment:

Pre-school/Daycare:

Primary (K-Grade 3

Junior (Grade 4-6):

Intermediate (Grade 7-8):

High School (Grade 9-12

Has there been remedial help given inside the school system? □ Yes □ No

If yes describe:

Behavior/Character

How would you describe your child?

What are your child's strengths?

What are your child's weaknesses

Have there been any specific behavior problems in the course of your child's development?

What kind of interests and activities does your child have? (Hobbies, sports, clubs) Please list them in order of preference beginning with the favorite activity:

How would you describe your child's social adjustment?

With peers?

With adults?

Please add any other comments you might have regarding your child's behavior and character:

Goals:

What are your goals for your child's program? (Please be as specific as possible)

1.

2.

3.

4.

5.

Who referred you / How did you hear about us?