ELITE
THERAPY

1505 Renaissance Boulevard, Edmond, OK 73013 Phone: (405) 850-8497

Pediatric Intake Form

The information you provide will help staff determine the care you need as well as any further assessments. A patient's individual background and cultural and family surroundings are important factors in her or his response to illness and treatment.

FAMILY AND MEDICAL HISTORY FORM

Patient's Name: _____ Date of Birth: _____

Parent/Legal Guardian name:_____

Home Address: _____City:_____ Zip:_____

Home Phone: _____ Business Phone: _____ Other (pager, cell) _____

E-mail Address: _____

PREGNANCY AND BIRTH HISTORY:

Please list all pregnancies in order (including this child, miscarriages, terminations or deceased):

PREGNANCY #	BIRTH WEIGHT	ANY DELIVERY, HEALTH OR DEVELOPMENTAL PROBLEMS	FATHER
1			
2			
3			
4			
5			
6			

Pregnancy complications with this child:

_____

_____

Gestational age at time of delivery (or # of weeks early or late): _____

What type of delivery? (please circle one) Vaginal or Cesarean Section (elective or emergency)

Birth Weight: _____ Length: _____

What were your child's APGAR scores? 1 minute _____ 5 minutes _____

Was your child in the NICU? Yes or No If so, how long? _____

Please describe any complications that occurred during NICU hospitalization:

_____

MEDICAL HISTORY:

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (tubes?)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint / bone problems (include x-rays, bone scans)	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions (include any EEG's)	
20			Stomach disorder/stomach pain	
21			Vomiting/digestion problems	
22			Failure to gain weight/feeding problems	
23			Constipation/diarrhea problems	

24			Dehydration episodes	
25			Hearing Loss/Ear disorder	
26			Significant accidents	
27			Head injuries or concussions	
28			Ingestion of toxins, poisons, foreign objects	
29			MRI / CAT scan / Injections	
30			Chronic medications (for what? when?)	
31			Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	

Has your child had any difficulties with feeding (i.e., sucking, swallowing, drooling, chewing, choking)? If yes, describe:_____

_____

Hospitalizations/Surgeries including approximate dates:

_____

_____

List the current medications your child is taking, if any (please include any over the counter medications or medications given as needed):

_____

_____

Is your child ALLERGIC to any drugs? Yes ___ No ___ If yes, what drugs? _____

_____

Please list reactions to allergy along with severity: _____

_____

Is your child ALLERGIC to any foods? Yes ___ No ___ If yes, what? _____

_____

Please list reactions to allergy along with severity: _____

_____

Does your child use any special equipment for daily activities, such as:

Glasses ____ Hearing Aids _____ Splints _____ Walker _____ Crutches _____ Wheelchair _____

Other: _____

Can your child see and hear well? _____Has vision/hearing been formally evaluated? _____

PREVIOUS EVALUATIONS/SERVICES:

Who *Where* *When*

Occupational Therapist _____

Physical Therapist_____

Speech Therapist _____

Psychologist _____

Other _____

HAS YOUR CHILD HAD ANY THERAPY THIS CALENDAR YEAR HERE OR AT ANOTHER FACILITY? YES ____ NO ____

NUTRITIONAL:

Please answer the following questions regarding your child's nutritional status:	**Yes**	**No**	**N/A**
My child has had no recent weight gain.			
My child has chewing or swallowing problems that make it difficult to eat. If yes, please explain:			
My child has had significant unexplained weight loss or gain in the past three months.			
My child has an open non-healing wound.			

Does your child have intolerances or dislikes of major food groups such as grains, fruits, starches, milk, protein, etc? If so, please describe:

_____

Has your child had problems with any of the following (beyond expected for child's age):

ITEM	**NO**	**YES**	**DESCRIPTION**	**EXPLANATION**
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Fire play or cruelty to animals	
11			Major mood swings	
12			Under or over reactive to sounds	
13			Under or over reactive to clothing	
14			Under or over reactive to taste	
15			Under or over reactive to smell	
16			Any unusual fears	

DEVELOPMENTAL HISTORY:

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE	GOOD/FAIR	POOR
Smiled						
Said first words / names single objects						
Combine words (i.e., me go, dad shoe)						
Use simple questions (i.e., where's mom?)						
Followed simple 1 step directions						
Said 2-3 phrases						
Knew colors						
Counted to 5						
Knew alphabet						
Held head up						
Rolled over						
Sat unsupported						
Crawled on hands and knees						
Stood alone						
Walked by self						
Ran by self						
Caught a thrown object						
Feeds self: (finger feed / eats with spoon / fork) Drink from: (bottle / spouted or special cup / regular cup)						
Bladder trained - days						
Bladder trained - nights						
Bowel trained						
Sleeps through the night						
Shows a hand preference (which?)						
Pick up Cheerios or other similar object						
Cut paper with scissors						
Scribble with a crayon						

GENERAL INFORMATION:

Parent's Name:_____ Date of birth:_____

Occupation:_____ Highest Educational Level:_____

Religion:_____ Relationship to child: (please circle): *Biological Adoptive Step Foster Other*

Parent's Name:_____ Date of birth:_____

Occupation:_____ Highest Educational Level:_____

Religion:_____ Relationship to child: (please circle): *Biological Adoptive Step Foster Other*

Brothers and Sisters (please include ages):_____

If both primary caregivers work, who cares for the child? _____

When is child with this caregiver?_____

Who lives in the home in which the child usually lives? _____

_____

FAMILY STRESSORS (please note/explain if any of the following stressful events happened in the last 12 months):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Marital separations/divorce	
2			Financial crisis	
3			Death in the family	
4			Job change/difficulties	
5			School problems	
6			Legal problems	
7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event	

SOCIAL:

Is your child in school? Yes _____ No _____ If yes, where? _____

What grade? _____ Is he/she in any special classes or have special needs?_____

Has your child missed any school because of this condition? _____ If yes, how much? _____

How much, if any, have the current symptoms interfered with your child's social activities? _____

_____

Describe your current support system at home for your child's treatment: _____

_____

REASON FOR VISIT:

Briefly state the reason your child is being evaluated (include reasons for each evaluation if receiving more than one): _____

_____

_____

When did you first notice the problem(s)? _____By whom? _____

How does your child usually communicate (gestures, single words, short phrases, sentences)?

_____

How does your child feel about their current condition? _____

CHILD/FAMILY CONCERNS AND GOALS

Please describe the major concerns and / or goals you have in seeking help for your child. List your concerns in order of their importance to you.

1. _____
2. _____
3. _____
4. _____
5. _____

OTHER

Who is your child's Pediatrician or Family Doctor? _____

Address: _____

Phone #:_____

Parent Signature: _____ Date: _____