Positive Steps
Pediatric Occupational Therapy Center, LLC

66 West Mount Pleasant Ave. Suite 204
Livingston, NJ 07039
973-994-4464

Tax ID # 20-33-7969
NPI # 1265644942

Dana Blumberg, OT
Director

# INITIAL INTAKE FORM

**We appreciate you taking the time to complete this form which will give us information instrumental in the treatment of your child. The more detail you provide, the better we can meet the needs of your child and family!**

**Today's Date _____Child's Full Name: _____**

**Sex: _____ Age: Years _____ Months _____ Date of Birth: _____**

**Address: _____**

**Pediatrician's Name: _____ Phone Number: _____**

| **Parent Information (**My child refers to me as _____**)** | |
|---|---|
| **Name:** | |
| **Address (if different than child's)** | |
| **Cell phone:** | **Business phone:** |
| **Occupation:** | **Education:** |

| **Parent Information (**My child refers to me as _____**)** | |
|---|---|
| **Name:** | |
| **Address (if different than child's)** | |
| **Cell phone:** | **Business phone:** |
| **Occupation:** | **Education:** |

**Are there any other individuals living at home (***sibling, grandparent, au pair***) Y/N**
**If yes, please list:**

| **Relationship to child** | **Name** | **Age** |
|---|---|---|
| | | |
| | | |
| | | |

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**What languages are spoken in the home? Please circle the primary language spoken:**

_____

****If your child has a custody schedule, please write it out and attach a copy to this form.**

## Birth History

**NOTE: If your child was adopted and/or you do not have access to birth or infancy information, you can skip to the section where your records begin.**

**Was your child adopted? ○ Yes ○ No**

**Was a surrogate used? ○ Yes ○ No**

| |
|---|
| **Was there anything unusual about the pregnancy or birth? ○ Yes ○ No**<br>If yes, please describe: |
| **List any complications and /or medical problems of mother: (infections, hypertension, hospitalizations, bleeding, gestational diabetes, bed rest, etc…?)** |
| **Was fertility treatment used? ○ Yes ○ No**<br>If yes, what type of procedure?: |
| **Please list any medications (prescribed or over the counter) taken during the pregnancy:** |

| | |
|---|---|
| **Mother was _____ years old at time of delivery** | **Child was born at _____ weeks** |
| **Delivery Method: ○ Vaginal ○ C-Section**<br>Reason for C-Section: | **Weighed _____** lbs **_____** oz |

**Please check all post-delivery complications that apply:**

**_____ Abnormal hearing screen**
**_____ Eye problems**
**_____ Feeding tube**
**_____ Infections**
**_____ Jaundice**
**_____ Seizures**
**_____ Heart problems**
**_____ Other**

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## Infancy Period

**Was your child ever hospitalized during 0-3 years? ○ Yes ○ No**

**If yes, please describe: _____**

| **Did your infant exhibit any of the following?** | |
|---|---|
| ○ **Did not enjoy cuddling** | ○ **Difficult to comfort** |
| ○ **Colic** | ○ **Difficulty nursing** |
| ○ **Excessive irritability** | ○ **Excessive restlessness** |
| ○ **Hard time settling down to sleep** | ○ **GERD/Reflux** |
| ○ **Allergies** | ○ **Ear infections** |

## Developmental Milestones

**Has your child ever regressed or "lost" a milestone they previously showed signs of? (For example: Stopped saying momma or no longer pulls self-up to stand, etc…) ○ Yes ○ No**

**Please give approximate ages if remembered:**

| ***Milestone*** | ***Approx Age*** | ***Milestone*** | ***Approx Age*** |
|---|---|---|---|
| **Rolls from stomach** | | **Babbles** | |
| **Rolls from back** | | **Says words** | |
| **Sitting alone** | | **Says phrases** | |
| **Crawling** | | **Says sentences** | |
| **Walking as primary form of getting around** | | **Feeds themselves with a spoon** | |
| **Was the crawling phase brief, absent or unusual? ○ Yes ○ No**<br>Describe tummy time with your child: | | | |

**Check all that apply:**

○ **Breast Fed** ○ **Bottle Fed**

○ **Feeding tube**

**Did your child transition easily to solids:**

○ **Yes** ○ **No**

If not, please describe:

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**How does your child communicate? Check all that apply**

**○ Speech**

**○ American Sign Language**

**○ Non-verbal/Gestures**

**○ Speech device**

**Which hand does your child prefer: _____**

| **Toileting: Check all that apply** | |
|---|---|
| **○ Toilet trained during the day** | **○ Willing to urinate outside the home** |
| **○ Toilet trained at night** | **○ Willing to defecate outside the home** |
| **○ Wipes, dresses and washes hands independently** | **My child was toilet trained at _____ yrs old** |

**Has your child ever been referred to the New Jersey State Early Intervention Program? ○ Yes ○ No**

| | **Dates** | **Outcome/Results** |
|---|---|---|
| **Direct Intervention** | | |
| **Speech** | | |
| **OT** | | |
| **PT** | | |

**If an early intervention report was provided, please attach it to these forms

**Sleep History**

**Check all that apply:**

| | | | |
|---|---|---|---|
| **Has a hard time settling down to sleep** | | **Wakes frequently during the night** | |
| **Snores regularly** | | **Has a history of night terrors** | |
| **Has teeth brushed before bed** | | **Has a history of sleepwalking** | |
| **Describe where your child sleeps (in their own crib, in a room with sibling, co-bed with parent, etc.). Let us know if this is an ideal situation for your family at this time:** | | | |

**What time is your child's bedtime? _____What time does your child fall asleep _____**

**What time does your child tend to wake up? _____**

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## Medical History

**Please check applicable boxes below:**

| | | | |
|---|---|---|---|
| **Allergies** | | **Major illness or injury** | |
| **Asthma** | | **Nail Biting** | |
| **Bed wetting** | | **Nightmares / Night terrors** | |
| **Bronchitis** | | **Seizures** | |
| **Ear Infections** | | **Sensory Defensiveness** | |
| **Epilepsy** | | **Skin Problems** | |
| **Feeding Problems** | | **Sleep Problems** | |
| **Gastrointestinal Problems** | | **Visual Problems** | |
| **Headaches** | | **Other** | |

**Please describe any allergies:** _____

**Does your child carry an EpiPen?** ○ **Yes** ○ **No**

**Does your child follow a special diet (gluten free, casein free)?** ○ **Yes** ○ **No** If yes, please describe:

_____

**Does your child take any supplements or other special oils or herbs?** ○ **Yes** ○ **No** If yes, please describe:

_____

**List any other serious injury, surgery or hospitalization:**

| **Incident** | **Date** |
|---|---|
| | |
| | |
| | |

**List any medical precautions we should be aware of when working with your child:**

_____

**Please list any medications your child is *currently* taking:**

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| Name of Medication | Dosage | Frequency | What Time of Day | Purpose of Medication |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Does your child have any *past* medication use? Y/N**
**If yes, what is the name of the medication, dosage, frequency and purpose?**_____

_____

**Has your child ever seen, been assessed or evaluated by any of the following specialists? Neurologist, Developmental Pediatrician, ENT, GI, Speech/Language, Audiologist, Chiropractor, Holistic, Music Therapist, Nutritionist, Occupational Therapist, Physical Therapist, Psychiatrist, Psychologist, ABA/Behaviorist, Optometrist** ("typical" eye doctor, provides annual eye exam, corrective lenses), **Ophthalmologist** (specialty MD focusing on medical and surgical eye treatments)

*Please fill out the following chart with all specialists seen*

| Specialty | Assessment Date | Treatment Date | Practitioner's Name | Diagnoses Provided |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |

**Current Status**

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| What are the presenting problems/issues for your child? Check all that apply: | | | |
|---|---|---|---|
| Relationships/socialization | | Motor Coordination | |
| Academic | | Visual Perception | |
| Activities of daily life (eating, dressing) | | Fine Motor | |
| Sensory | | Handwriting | |

**Please describe:**

_____

_____

_____

**When did you first notice the problem?**_____

**What, if anything, was done once you noticed:**

_____

_____

**Current Therapy:**

**Has your child ever had any previous Occupational Therapy Evaluations? Y/N**

**If yes, please list date and describe why therapy ended:**

_____

_____

**Does your child identify with a different gender than the one assigned at birth? Yes/No/Rather Not Say**

**Is there anything you would like us to know about gender and your child?**

_____

_____

**Day Care and Educational History:**

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**Who cares for your child most of the time?**

_____

**Does your child attend:**

○ **Daycare** ○ **School** ○ **Homeschool**

**Name of school/daycare:** _____

**Teacher name:** _____

**Grade level:** _____ **Anticipated kindergarten starting year:** _____

**Check all that apply:**

| | | | |
|---|---|---|---|
| **Mainstream/General education classroom** | | **IEP** (individualized education plan with specialized instruction provided) | |
| **Self-contained classroom** | | **504** (in-school accommodations) | |
| **Inclusion classroom** | | **Skipped grades** (which?) | |
| **Resource room** | | **Repeated grades** (which?) | |

**Does your child have any social, emotional or academic difficulties in school?**

_____

_____

**How do you discipline your child if/when needed? Do they respond well to your method of discipline?**

_____

_____

**Please describe some of your child's gifts/strengths**

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**What are your child's favorite things/What makes your child excited (foods, TV shows, movies, characters, sports/teams, music, etc)?**

**Please list any afterschool activities your child participates in:**

| Typical Weekday Schedule | Typical Weekend Schedule |
|---|---|
| | |

**Goals:**

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**What are your goals for your child's OT program? Please be as specific as possible.**

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

**Name of Parent/Legal Guardian/Relationship to patient**

_____

**Signature:** _____ **Date:** _____

## Thank you again for completing this form!