Name: _____ DOB: _____

Therapy Intake Questionnaire

Please complete this questionnaire to the best of your knowledge. The more information you can provide the better that we can serve your child

Why are you coming in for a therapy evaluation? What are your concerns? What are you hoping to get out of the evaluation?

_____

_____

_____

_____

_____

_____

Who is your child's Pediatrician: _____

Does your child have a confirmed diagnosis? If so, what is it?

_____

Does your child have any health concerns that we need to know about?

_____

_____

Has your child had an evaluation by a PT/OT/SLP/DT before? **Y** / **N**

*(If **Yes** , please bring notes/evaluation to appointment)*

Educational Information

School/Educational program or daycare currently attending _____

Grade level _____

IEP or Early intervention Services, Early/Head Start received? **Y** / **N**

If yes, what are the services for? _____

_____

_____

Does your child's teacher or daycare provider have concerns about your child's development in any of the following areas?

Gross motor skills_____ Fine motor skills _____Social skills _____ Self-help abilities_____

Name: _____ DOB: _____

Birth History

Child was born: **full-term** / **premature** _____

Vaginal / **C-section**

Complications: _____

Did your child stay in the NICU/how long? _____

Developmental History

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Rolled over								
Crawled								
Walked alone								
Walked up Stairs								
Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								
Drank from cup								
Dressed self								

Name: _____ DOB: _____

Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- ☐ Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- ☐ Talks excessively, interrupts often, doesn't listen
- ☐ Low energy/fatigue
- ☐ Poor concentration
- ☐ Difficulty initiating tasks
- ☐ Difficulty completing tasks
- ☐ Difficulty following instructions
- ☐ Engages in impulsive behaviors (acts before thinking)
- ☐ Immature compared to peers
- ☐ Engages in physically dangerous activities
- ☐ Often argumentative with adults
- ☐ Often actively defiant to adult requests and rules
- ☐ Blames others for own mistakes
- ☐ Often angry or resentful
- ☐ Somatic complaints of not feeling well
- ☐ Excessive separation difficulties
- ☐ Easily frustrated
- ☐ Lies
- ☐ Steals
- ☐ Aggressive towards others
  - Adults
  - Peers
- ☐ Often depressed/irritable mood
- ☐ Often loses things, very disorganized compared to others his/her age.
- ☐ Shy
- ☐ Feeling of worthlessness or low self-esteem
- ☐ Withdrawn
- ☐ Overly anxious or fearful
- ☐ Sleeping too little/insomnia
- ☐ Sleeping to much
- ☐ Difficulty making decisions
- ☐ Cries easily
- ☐ Temper tantrums
- ☐ Rapid mood changes/mood swings
- ☐ Suicidal thoughts
- ☐ Excessive need for reassurance
- ☐ Poor appetite
- ☐ Overeats
- ☐ Explosive temper with minimal provocation
- ☐ Odd fascinations
- ☐ Unrealistic worry about futures events
- ☐ Substance abuse
  - Drug
  - Alcohol
  - other

Please explain all checked items: _____

_____

_____

_____

_____

Name: _____ DOB: _____

D. Home Behavior:

How often is each of the following settings a *problem* for your child?

While getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently
When eating at the dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
When playing by him/herself	☐ Rarely	☐ Sometimes	☐ Frequently
When playing with siblings/other children	☐ Rarely	☐ Sometimes	☐ Frequently
When with a babysitter or daycare	☐ Rarely	☐ Sometimes	☐ Frequently
In public places (church, store)	☐ Rarely	☐ Sometimes	☐ Frequently
When in the car	☐ Rarely	☐ Sometimes	☐ Frequently
When told to do something he/she doesn't want to do	☐ Rarely	☐ Sometimes	☐ Frequently
During sit-down homework time	☐ Rarely	☐ Sometimes	☐ Frequently
When watching TV or playing video games	☐ Rarely	☐ Sometimes	☐ Frequently

Sensory Processing

Does your child struggle with sensory processing in the following areas?

Tactile avoidance or seeking (Ex. Avoids: Distress with grooming routines, dislike tags, seams in socks, or being messy / Seeks: touch everything, enjoy being messy)

_____

Auditory sensitivity (Ex. Cover ears with noises, become upset or startle easily to loud noises, tune out noise or not seem to notice when people are talking to them)

_____

Clumsy or uncoordinated (Ex. Trip or fall, have difficulty navigating curbs or stairs, be late with motor development, struggle with sports or ball skills)

_____

Avoids typical play of kids his/her age (Ex. Prefer to play alone, often avoids play with others, has difficulty tolerating change in their play routines)

_____

Emotionally reactive (Ex. Easily becomes upset, gets frustrated easily, has frequent meltdowns or tantrums, difficult to console)

_____

Name: _____ DOB: _____

Difficulty with transitions (Ex. Melts down when asked to transition or stop activity, needs lots of assistance to stop activity and move on to the next task)

_____

Does your child struggle with fine motor skills? (Ex. Avoid play with small objects, have poor grasp on writing tools, avoid coloring)

_____

Does your child struggle with self-care? (Ex. difficulty with dressing, managing zippers/buttons/snaps, unable to tie shoes, poor grasp or use of fork/spoon, difficulty with bathing/grooming, decreased awareness of needing to use the bathroom, inability to wipe self)

_____

Does your child struggle with any of the following:

Walking / Running: _____

_____

Coordination / Balance: _____

_____

Strength / Flexibility: _____

_____

Sports / Other Injury: _____

_____

Does your child currently do any of the following: (please check all that apply):

❑ repeat sounds, words, or phrases over and over

❑ understand what you are saying

❑ retrieve/point to common objects upon request (ball, cup, shoe)

❑ follow simple directions ("Shut the door" or "Get your shoes")

❑ respond correctly to yes/no questions

❑ respond correctly to who/what/where/when/why questions

Name: _____ DOB: _____

Your child currently communicates using: (please check all that apply):

❑ Body Language ❑ 2 to 4 word sentences

❑ Words (shoe, doggy, up) ❑ Other _____

❑ Sentences longer than 4 words

How much of your child's speech do you understand?_____

How much of your child's speech do others understand?_____

Does your child:

❑ Engage in turn taking ❑ Greet people arriving or leaving

❑ Initiate conversation ❑ Maintain a topic

Does your child currently…

_____ Use a pacifier?

_____ Choke on food or liquids?

_____ Put toys, objects or clothing in his/her mouth?

_____ Brush his/her teeth and/or allow brushing?

_____ Hold food in his/her mouth?

_____ Sleep with mouth open, or is his/her mouth open at rest?

_____ Snore?

_____ Drool?

_____ Eat in a messy manner?

_____ Have difficulty with use of a straw or bottle?

_____ Suck his/her thumb?

Is he/she a picky eater? ____ Yes _____ No

If so, please explain:

_____

_____

Name: _____ DOB: _____

Does your child currently…

_____ Repeat sounds, words or phrases over and over?

_____ Understand what you are saying?

_____ Retrieve/point to common objects upon request (ball, cup, shoe)?

_____ Follow simple directions

_____ Respond correctly to yes/no questions?

_____ Respond correctly to who/what/where/when/why questions?

_____ Ask questions of others?

_____ Communicate his or her basic wants, needs, and feelings?

_____ Comment on daily activities, objects, and people within his or her environment?

_____ Participate in conversations with others?

Please check below any/all forms your child currently uses to communicate:

_____ Body language

_____ Words (shoe, doggy, up)

_____ Sentences longer than four words

_____ Sounds (vowels, grunting)

_____ 2 to 4 word sentences

_____ Other

Please describe your child's strengths _____

_____

_____

What do you want us to know about your child that you are not comfortable talking about in front of your child during the evaluation?

_____

_____

2713 SE I Street, #5, Bentonville, AR 72712 Ph: 479-250-4355 Fax: 479-553-7954