Cooper
Therapy Connections PLLC
Speech and Language, Feeding, Occupational Therapy, Counseling and Tutoring
(779) 234-8997

CHILD INTAKE FORM / CLIENT HISTORY

TODAY'S DATE: _____

CLIENT NAME: _____ NICKNAME:_____

DOB: _____AGE: _____ ☐ Male ☐ Female

Diagnosis (if known): _____

Home Address: _____ City, State, Zip: _____

Parent Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Parent Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Parent Email #1:_____

Parent Email #2: _____

Emergency Contact

Name: _____

Relationship to child: _____

Contact Information: _____

HEALTH

Client's Physician: _____ Phone Number:_____

Physician's Address: _____

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone Number _____

Physician Address: _____

Secondary Physician: _____ Phone Number _____

Physician Address: _____

Family Background

Parent 1 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Parent 2 Name: _____ Age: _____

Occupation: _____ Education Level: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What adults does the child live with? Check all that apply:

☐ Birth Parent(s)

☐ Adoptive Parent(s)

☐ Foster Parent(s)

☐ Grandparent(s)

☐ Both Parents

☐ Parent 1 Only

☐ Parent 2 Only

☐ Other:

_____

Does the child have siblings or are there other siblings in the home?

Child 1 Name: _____ Age: ___ Sex: ___ Speech Issues:_____

Child 2 Name: _____ Age: ___ Sex: ___ Speech Issues:_____

Child 3 Name: _____ Age: ___ Sex: ___ Speech Issues:_____

Child 4 Name: _____ Age: ___ Sex: ___ Speech Issues:_____

Child 5 Name: _____ Age: ___ Sex: ___ Speech Issues:_____

Language(s) spoken in the home: _____

Who speaks the other language(s)? _____

Is there anything additional you would like to share about the family / home environment?

Evaluation

Briefly describe why you're seeking an evaluation by an occupational therapist at this time:

What are you expecting out of this evaluation / meeting?

Has the child had a previous evaluation/treatment? ☐ Yes ☐ No

By whom: _____When: _____

Describe the results:

Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons:

At what age did you first notice the problem? _____

How do the child's difficulties impact the family?

Is the child aware of or frustrated by their difficulties?

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐ Yes ☐ No

Describe: _____

2. Was there any stress during the pregnancy? ☐ Yes ☐ No

Describe: _____

3. Were there any complications during labor or delivery? ☐ Yes ☐ No

Describe: _____

4. What was the mother's age at the time of delivery? ____ years

Child's Health:

1. How many weeks gestation was the child born? _____ weeks (40 is typical)

2. The child was _____ lbs ____oz and _____ inches at birth

3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section

4. Please describe any complications or concerns during labor or delivery:

Check and describe all that apply:

☐ Adenoidectomy	☐ Ear infections	☐ Seizures
☐ Asthma	☐ Ear tubes	☐ Sensory issues
☐ Behavior Issues	☐ Encephalitis	☐ Sleep issues
☐ Brain injury	☐ Frequent colds	☐ Tongue tie
☐ Breathing problems	☐ High fever	☐ Tonsillitis
☐ Cardiac issues	☐ Measles	☐ Tonsillectomy
☐ Chicken pox	☐ Meningitis	☐ Traumatic brain injury
☐ Diabetes	☐ Mumps	☐ Vision issues

For those that were checked above, please describe:

Is the child up to date with immunizations: ☐ Yes ☐ No

Please describe:

Has the child ever had surgery? ☐ Yes ☐ No

Please describe:

Has the child ever been hospitalized: ☐ Yes ☐ No

Please describe:

Has the child ever been in a serious accident? ☐ Yes ☐ No

Please describe:

Does the child have a chronic illness? If so, please describe:

Is the child currently on any medications? If so, please list medication name and reason for medication:

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

Does the child have any known allergies? ☐ Yes ☐ No

Describe:

Does the child currently use any equipment? (communication device, walker, etc.) Describe:

Describe the child's current health status:

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

☐ Developmental Pediatrician _____

☐ Neurologist _____

☐ PT _____

☐ OT_____

☐ SLP _____

☐ Behavioral Therapist _____

☐ Educational Consultant _____

☐ Psychologist / Psychiatrist _____

☐ Vision Therapist _____

☐ Other: _____

Developmental History

At what age did the child do the following:

Sit alone: _____

Crawl: _____

Stood Up: _____

Walk: _____

Made Sounds: _____

First Word: _____

Combined Words: _____

Sentences: _____

Fed Self: _____

Understood by Others: _____

Toilet Trained: _____

Dressed Self: _____

Does the child do any of the following:

☐ Choke on liquids

☐ Choke on foods

☐ Avoid foods

☐ Maintain a special diet

☐ Use a pacifier / suck thumb

☐ Mouth objects

Please describe any of the above:

Does the child have any difficulty with the following:

☐ Attention	☐ Following directions	☐ Remembering
☐ Frustration Tolerance	☐ Excessive drooling	☐ Maintaining eye contact
☐ Aggression	☐ Chewing or eating	☐ Transitions
☐ Anger	☐ Producing speech sounds	☐ Other difficulties:
☐ Answering simple questions	☐ Reading	_____
☐ Understanding people	☐ School work	_____

Please describe any of the above:

Educational History

Is the child currently enrolled in daycare/ school: ☐ Yes ☐ No

What is the name of the program? _____

What day(s) do they attend? _____

What is their grade level: _____

Type of classroom: _____

If they receive any accommodations, please describe:

Please describe any educational difficulties or learning challenges that this child has faced:

Social History Describe how the child interacts with parents, siblings, or other family members:

Please describe the communication difficulties the child faces in the home environment:

Describe any significant events or changes within the home:

What are the child's strengths?

What are the child's weaknesses?

What are the child's favorite activities?

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior?

Does the child become easily frustrated with certain activities? If so, please explain:

Describe how the child interacts with other children:

What are your goals for the child over the next 6 months?

What are your goals for the child over the next 5 years?

Is there anything else that is important for us to know about the child?

How did you hear about Cooper Therapy Connections PLLC?

Person filling out the form: _____

Signature:_____ Date:_____

Relationship to the child: _____