Cooper
Therapy Connections PLLC
Speech Therapy, Evaluations, Counseling and Feeding Therapy
(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)? _____

Describe the child's use/understanding of the language(s):

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

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

Parent Questionnaire

What does your child spend the most time playing with? _____

Does your child like to read books/how often? _____

Does your child participate in pretend/imaginative play?_____

Does your child prefer to play alone or with others? _____

Describe what makes your child anxious:

_____

_____

_____

How do you know he is anxious/what does he do to tell you or let you know he is anxious?

_____

_____

_____

Have you found any strategies helpful/not helpful to reduce his anxiety?

_____

_____

_____

How is your child doing academically in school?

_____

_____

_____

How is your child doing socially in school?

_____

_____

_____

Does your child have an IEP/receive any services at school?

_____

What textures does your child not like to touch?

- ☐ Hard
- ☐ Soft
- ☐ Squishy
- ☐ Slimy
- ☐ Sticky
- ☐ Fuzzy
- ☐ Rough
- ☐ Bumpy
- ☐ Wet
- ☐ Other? _____

Describe any other sensory sensitivities your child may have besides food (examples - loud noises, hand dryers, automatic flushing toilets, specific clothing, getting wet, sensitivity to temperature, smells, etc.)

_____

_____

_____

Does your child use utensils at meal time? YES NO

Does your child drink through a straw? YES NO

What drinks does your child like? _____

What drinks does your child not like?_____

How often do you attempt to introduce a new food at home? _____

How does your child react when a new food is introduced at home?

_____

_____

_____

What strategies have you found to be effective/ineffective when introducing/getting your child to try a new food?

_____

_____

_____

How does your child react when you put a new food on his plate?

_____

Does it bother your child if the food on his plate touches? _____

Does your child complain about being hungry often? _____

Do you currently have any "rules" or routines that you follow at meal time? (examples: can't leave the table until your plate is clean, try one bite of everything, smell each item on your plate, etc.)

_____

Would you describe your child as a fast or slow eater? _____

Does your child seem full when he is done eating? _____

Describe what your child does when he does not want to eat something:

- ☐ Cries
- ☐ Screams
- ☐ Gags
- ☐ Vomits
- ☐ Throws food
- ☐ Pushes it away
- ☐ Says "No"
- ☐ Other: _____

Describe what your child eats and how he reacts to eating at

A restaurant: _____

School: _____

Are there any rewards/punishments when your child eats/tries a new food?

_____

_____

What are common meals that your family eats that you would like him to be able to enjoy also?

_____

_____

Have there ever been any concerns regarding gastrointestinal health/has this ever been evaluated?

_____

Does your child have regular bowel movements/constipation/diarrhea?

_____

Describe eating habits of parents, siblings, or other individuals that may influence your child:

_____

_____

What is the biggest challenge that you face as a parent at meal time/getting your child to eat?

_____

_____

Please list previous foods that your child has eaten for periods of time, but no longer will eat:

_____

_____

Please list the top 5 foods your child will **willingly eat regularly:**

1.

2.

3.

4.

5.

Please list additional foods that your child will eat but does not enjoy/is a battle/takes extra effort to get him to eat:

_____

Please list the top 5 foods you **would like** your child to eat more of:

1.

2.

3.

4.

5.

Please list 5 common meals/foods that **everyone** in your home likes besides _____.

1.

2.

3.

4.

5.

Please list 5 foods that are **disliked** by your family/that you never buy/you are not likely to prepare:

1.

2.

3.

4.

5.

What guidance, support, tips, strategies, ideas, help would you like us to provide?

_____

_____

Any additional questions you have/other important information you think we should know:

_____

_____

_____