Thank you for allowing us the opportunity to provide services for your child and your family. An important part of the intake and assessment process is getting accurate information from you. Please print this forms and ***mail or fax (724 942-6104) to the clinic*** ***before your first appointment****. It is important that we receive these forms prior to your first appointment so that we can plan the best possible assessment for your child. (Sorry, form cannot be emailed due to confidentially issues.)If you wish to be on a call list to move your appointment earlier if a cancelation occurs please call.*

WHS **Children's Therapy Center: INTAKE/History**

Patient's Full Name:_____ **DOB:**_____
Last First MI

Father's Info:

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: Home:_____

Work:_____ **Cell:**_____

Father's Occupation:_____

Mother's Info:

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: Home:_____

Work:_____ **Cell:**_____

Mother's Occupation:_____

Siblings: (names & age)_____

Patient's Primary Physician:_____ **Referred By:**_____

Diagnoses:_____ _____

Medications and dosages:_____

Allergies:_____

Medical Conditions:_____

Immunizations up-to-date:_____ **Yes**_____ **No. If no, why:**_____

Has your child had any surgeries, hospitalizations or invasive procedures in the past?_____

_____

Note: (If recent surgery is Physical Therapy related will need script with list of restrictions/weight bearing/non-weight bearing)

Does your child have any hearing/vision problems?___Yes ____No Please describe issues:_____

_____

Primary Insurance:_____

Member ID:_____

Group ID:_____

Guarantor:_____

DOB:_____ **SS#:**_____

Secondary Insurance:_____

Member ID:_____

Group ID:_____

Guarantor:_____

DOB:_____ **SS#:**_____

____

What is your Primary concern for your child?____

What information do you hope to gain? ____

Does your child attend school? Yes ___No _____ NA ___ Where/What Grade?_______________________________

Has your child ever received therapy services in the past/currently receiving services? (where/when/what service(s):_______________

____

What is your child's primary form of mobility (walking, crawling, wheelchair)______________________________

How would you describe your child's gross motor skills (same as peers, behind peers; examples running, jumping, skipping, catching a ball):____

____

How would you describe your child's fine motor skills (same as peers, behind peers; examples handwriting/scissor skills. Can they:

Manipulate small objects easily?____

Can your child dress themselves independently? NA __ Yes ____ No ___________(Describe):

Do they have issues with zippers; snaps or buttons?____

Does your child exhibit any sensory issues (do they have aversions to certain foods/textures, loud noises, do they dislike certain materials?)____

____

How would you describe your child's speech and language skills? (Verbal; Nonverbal; Minimally Verbal; Sign Language; Uses a Device) List Device(s):____

____

Is your child currently experiencing any pain? Yes__________No ____________

If yes, where are they experiencing pain?____

Can your child feed themselves? Yes_____________No ____________Needs assistance? ___________________________

Any nutritional concerns? Yes____________ No ______________

If yes, what are the concerns?____

Special Diets (gluten/casein free):________________**Yes** ___________________**No**

If yes, what diet/diet restrictions:____

Do you have any behavior concerns for your child? _______________**Yes** ____________ **No**

If yes, what are the concerns?____

____

How does your child get along with other children?____

____

Any additional information we should know? ____

Office use

OT-Date:______________Time:_______________ SLT-Date:_____________Time:________________

PT Date:______________Time:________________ SS-Date:______________Time:_______________