leading edge PHYSIOTHERAPY

PEDIATRIC DISCOVERY/ASSESSMENT INTAKE FORM

Part 1

Child's Name	
Date of Birth	
Gender	
Parent/Guardian Name	
Address: Street, City, Province, Postal Code	
Home Phone	
Cell Phone	
Email Address	
Language(s) Spoken in Home	
Pediatrician full name and number	
Other Children in Family; Ages of siblings	

BACKGROUND INFORMATION

Describe your primary concern(s) regarding your child... (What kind of help or information are you looking for with your child?)	
At what age did you first become concerned?	
Are there any other family members with a history of developmental concerns (i.e., learning disabilities, developmental delays, autism, etc.)	
Has your child previously received therapy and/or services from other therapists or programs? If so, what services were provided? Do you have reports or assessments from these services?	

Client Name:.. File #..

How did you hear about our services? (Doctor referral, advertisements, social media, other parents, etc.)	
When did your child last have their eyes/vision examined by an optometrist or ophthalmologist? Results? Prescription glasses? Follow-up appointments?	
Has your child's hearing been checked/assessed? When? Where?	

PRENATAL/BIRTH HISTORY

<table>
<tr><td colspan="2">History of pregnancy (i.e., medication, health of mother, complications):</td><td colspan="3"></td></tr>
<tr><td rowspan="2">Length of pregnancy:</td><td>Full Term</td><td colspan="2"></td><td>Weeks Gestation</td></tr>
<tr><td>Premature</td><td colspan="2"></td><td>Weeks Gestation</td></tr>
<tr><td colspan="2">Type of delivery</td><td>Vaginal</td><td>C-Section</td><td>Breech</td></tr>
<tr><td colspan="2">Note complications of labor/delivery, including medications</td><td colspan="3"></td></tr>
<tr><td colspan="2">Birth Weight</td><td colspan="3"></td></tr>
<tr><td colspan="2">Length of Hospital Stay</td><td colspan="3"></td></tr>
<tr><td colspan="2" rowspan="4">Did/Does your child have difficulty</td><td>Sucking</td><td>Yes</td><td>No</td></tr>
<tr><td>Swallowing</td><td>Yes</td><td>No</td></tr>
<tr><td>Chewing</td><td>Yes</td><td>No</td></tr>
<tr><td>Changing to solids</td><td>Yes</td><td>No</td></tr>
</table>

DEVELOPMENTAL HISTORY

<table>
<tr><td>Present level of activity</td><td>Active</td><td>Typical</td><td>Low Arousal</td></tr>
<tr><td rowspan="2">Developmental milestones in early Infancy</td><td>Sat alone</td><td>Crawling</td><td>Walking</td></tr>
<tr><td>Babbling</td><td>First Words</td><td>Sentences</td></tr>
<tr><td>Present Behavioral Concerns (Please list):</td><td colspan="3"></td></tr>
</table>

Client Name:………………………………………………………… File #…………………………………………………………

Present Sleep Habits: **What time do you start your child's bedtime routines? ………… PM** **Describe your child's bedtime routine:** **Does your child put him/herself to sleep?** **Do you rock/lay with them, etc.?** **Hours of sleep at night: ………………….** **Hours of sleep at naptime: ………………….**	 Yes No Yes No

MEDICAL HISTORY

List any diagnosis:	
Significant illnesses and or infections (give approximate dates):	
List present/past medications:	
List vaccinations and dates of immunization:	
List surgeries or hospitalizations (give approximate dates):	
List any allergies (food and non-food):	
Did/does your child suffer from frequent ear infections? If yes, list the number since birth.	

The following questions are helpful in giving us a clearer and more complete picture of your child from early infancy to their present developmental stage. Some of the questions may not apply to your child depending upon their age. Please cross out items that do not apply. Circle the choice that applies and add details if necessary. Thank you for your time. We appreciate that you be as complete as possible so that we may better get to know your child.

Client Name:……………………………………………………… File #……………………………………………………….

SPEECH-LANGUAGE DEVELOPMENT

Was your infant:	A quiet baby	Yes	No
	A frequent crier	Yes	No
	Irritable	Yes	No
	Interested in looking at things in their environment	Yes	No
	Alert/attentive to sounds	Yes	No
At what age did your child:	Babble		
	Understand routine words/phrases (go bye bye, etc.)		
	Imitate Speech Sounds		
	Say first words		
	Use two or more words in a phrase		
Did your child begin to babble and then stop?			
At present, does your child have:	Understandable speech	Yes	No
	A loud voice	Yes	No
	A monotone voice	Yes	No
	A hoarse voice	Yes	No
Does your child:	Respond to sound	Yes	No
	Respond to loud noises only	Yes	No
	Respond to their name?	Yes	No
	Sing and/or say verses or rhymes (e.g., Twinkle Twinkle, Baby Shark, the Alphabet Song, etc.)	Yes	No
	Stutter?	Yes	No
	Has your child worked with a Speech Language Pathologist before?	Yes	No

Client Name:………………………………………………………… File #……………………………………………………………

EDUCATIONAL BACKGROUND

Name of Present School/Daycare	
Names of Past Schools/Daycares	
Grade	
School-based services (e.g., OT, PT, SLP, ELL, etc.)? Please list or describe.	
Does your child receive/participate in any out of school, supplemental services (e.g., private therapy, FSCD, CASA, Crystal Kids, etc.)? If so, please list/describe.	
Concerns with Academic/Cognitive areas?	My child enjoys school? Yes No My child finds certain subjects or classroom tasks challenging (describe) …………………………………………………………………………………………………… …………………………………………………………………………………………………… My child dislikes or is anxious/frustrated with school? Yes No
Concerns with Play Skills?	
Concerns with Everyday Living Skills?	
Concerns with Social Skills?	My child readily interacts with their peers and/or other children: Yes No My child has a wide circle of friends and playmates. Yes No My child prefers to play with siblings, relatives, or close family friends. Yes No My child is happiest/most content to play on their own. Yes No
What activities or classes does your child participate in outside of school (e.g., Gym & Swim, music lessons, soccer, swimming, art classes, Scouts/Brownies, etc.)	

Client Name:………………………………………………………… File #…………………………………………………………

Activity Level: (Please Circle) **My Child:**	Runs/plays/bikes/gets high levels of movement/exercise Activity ____ minutes/day Plays outdoors ___minutes/day Likes to read Prefers crafts, colouring, drawing, etc.

Technology: **My Child:**	Watches television ____ hours per day Plays with or uses technology (tablet/phone/game system) _______ minutes/ _______hours per day (Please estimate)

FUNCTIONAL STATUS

Eating and Drinking **My child:**	Finger feeds	Yes	No
	Use a spoon	Yes	No
	Use a fork	Yes	No
	Use a knife	Yes	No
	Drink from an open cup	Yes	No
	Drink from a straw	Yes	No
	Sits in a chair at a table during meals	Yes	No
Clothing Management (Dressing?) **My child:**	Chooses their own clothes to wear	Yes	No
	Puts their clothes on in the correct order (e.g., underwear before pants; snowpants before boots, etc.)	Yes	No
	Removes clothing/Takes clothes off	Yes	No
	Puts clothing on	Yes	No
	Starts their own zippers	Yes	No
	Fastens buttons	Yes	No
	Pulls off socks Puts on socks	Yes Yes	No No
	Puts shoes/boots on Removes shoes/boots Pulls open Velcro tabs on shoes/boots Tie shoelaces	Yes Yes Yes Yes	No No No No

Toothbrushing **My child:**	Brushes their own teeth Allows me to brush their teeth	Yes Yes	No No
Toileting **My child:**	Uses the bathroom independently	Yes	No
Environmental Considerations or Adaptations (Please circle those that apply)	Wheelchair Orthotics Bathroom tools/modifications Custom seating Specialized tools (e.g., built-up handles, angled Utensils, switch access, etc.) Assistive communication devices Switch access Ramps, elevators		

Just a little more to go during this Discovery period…. as we get to know your child even better we will be able to help them reach their potential:

Please describe the **chores/routines** that your child participates in or helps with at home (e.g., putting toys away, making their bed, setting the table, washing dishes, etc.).

My child's favourite activities are: ……………………………………………………………………..

My child's current interests/hobbies are: ……………………………………………………………

To relax or unwind, my child prefers to: ……………………………………………………………

I know my child is upset or anxious when they show/do: ……………………………………………

My child is really good at/confident with: …………………………………………………………

They need help/encouragement with: ………………………………………………………………

I wish my child could: ………………………………………………………………………………

To better support/understand my child, I need to learn about:

……

……

CONSENT

I certify that the above information is true and correct to the best of my knowledge. I certify that I am the legal guardian of the above-named patient. I give permission to the practitioner to assess, administer and perform such procedures as may be deemed necessary for treatment. I understand that I have the right to refuse assessment / treatment of my child at any time.

Child's Full Name ………………………………………………………………………………

Parent(s)/Guardian Name (Please Print) …………………………………………………

Parent(s)/Guardian Signature ✍ …………………………………………… Date ……………..

Client Name:…………………………………………………… File #…………………………………………………