Positive Steps
Pediatric Occupational Therapy Center, LLC

66 West Mount Pleasant Ave. Suite 204
Livingston, NJ 07039
973-994-4464

Tax ID # 20-3307969
NPI # 1265644942

Dana Blumberg, OT
Director

INITIAL INTAKE FORM

I appreciate you taking the time to complete this form which will give us information instrumental in the treatment of your child.

Today's Date _____

Child's Name: _____
(Last) (First) (Middle)

Sex: _____ **Age: Years**_____**Months**_____ **Date of Birth:** _____

Address: _____

Pediatrician's Name: _____ **Phone Number:** _____

Parent Information
Name:
Address(if different than child's)
Home phone:
Cell:
Business:
Occupation:
Education:

Parent Information
Name:
Address(if different than child's)
Home phone:
Cell:
Business:
Occupation:
Education:

Sibling Information	**Name**	**Age**
Brother/Sister		
Brother/Sister		
Brother/Sister		
Brother/Sister		

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Are there any other individuals or family members living at home/caring for your child? Y/N
If yes, please list:

Name	Relationship to child

What is the primary language spoken in the home: _____
Any other language spoken at home please list: _____, _____

Birth History:

Was there anything unusual about the pregnancy or birth? Y/N If yes, please describe:
_____

Any complications and /or medical problems of mother: (infections, hypertension, hospitalizations, bleeding, gestational diabetes, bed rest, etc…?) _____

Was fertility treatment used? Y/N If yes, what type of procedure?: _____

Please list any medications (prescribed or over the counter) taken during the pregnancy:
_____

Birth mother's age at time of delivery: _____

Delivery Method: Vaginal_____ C-Section_____: If C-Section, why?_____

Any complications during the delivery?_____

Was your child:
Full Term _____ Premature _____ , if so how many weeks? _____

Gestational Age _____ Birth Weight: _____lbs. /oz.

Apgar Scores: _____

Number of days infant was in the hospital after delivery _____

Any post-delivery complications with infant? _____

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Was hearing screening normal?_____
Were there any eye problems?_____
Were there any infections?_____
Any other issues (seizures, heart problems, feeding by tube, jaundice)_____

Infancy Period:

Was your child: Breast Fed _____ Bottle Fed _____

Did your child have any issues with GERD, allergies, ear infections or feeding during infancy?_____

Did your child transition easily to solids: Y/N

Was your child ever hospitalized during 0-3 years? Y/N
If yes, please describe: _____

Did your infant exhibit any of the following?:

	Yes	No
Did not enjoy cuddling		
Difficult to comfort		
Colic		
Difficulty nursing		
Excessive irritability		
Excessive restlessness		
Hard time settling down to sleep		

At how many months did your infant begin to sleep through the night?_____
Did your child engage in tummy time during infancy?_____

Developmental Milestones:

Please give approximate ages if remembered and comment on anything unusual, such as method used for "crawling:"

Rolling over:
From stomach_____
From Back_____
Sitting alone _____
Crawling: _____
Was crawling phase brief, absent or unusual? _____
Walk as primary form of getting around: _____

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Verbal:
Babble: _____

Say Words: _____

Say Phrases: _____

Say Sentences: _____

Please describe how your child communicates: _____

Which hand does your child prefer: Right: _____ Left: _____

At what age did your child feed themselves with a spoon? : _____

Is your child toilet trained during the day: Y / N
Is your child toilet trained at night: Y / N
What age was your child toilet trained?_____

Has your child ever regressed or "lost" a milestone they previously showed signs of? (For example. Stopped saying momma or no longer pulls self-up to stand, etc…) Y/N
If yes, please describe: _____

Has your child ever been referred to the New Jersey State Early Intervention Program? Y/N If yes, see below:
What services were provided?_____
When were the services provided?_____
What were the results of the services provided?_____
Was a report provided? Y/N

Sleep History:
What time is your child's bedtime?_____ What time does your child fall asleep?_____
What time does your child tend to wake up?_____
Where does your child sleep (In own crib, co-bed with parent)?_____
Does your child have a hard time settling down to sleep? Y/N
Does your child wake frequently during the night? Y/N
Does your child snore regularly? Y/N
On average, how many hours of sleep does your child get a night?_____
Has your child had night terrors? Y/N
Does your child have teeth brushed before bed? Y/N

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Parental Statement of Problem:

Please approximately rate your child's level with the following skills:

	Above Average	Average	Poor	Not Yet Developed
Walking				
Running				
Catching				
Scribbling With A Crayon				
Self-Feeding				
Self-Dressing				
Playing With Toys				
Playing With Peers				

What are the presenting problems/issues for your child: Please check box

Relationships/Socialization	
Academic	
Activities of daily life (eating, dressing)	
Sensory	
Motor coordination	
Visual Perception	
Fine motor	
Handwriting	
Low muscle tone	

Please describe:

_____

_____

_____

When did you first notice the problem: _____

What if anything was done once you noticed**:** _____

_____

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Medical History:

Please check applicable boxes below:

Allergies		Major illness or injury	
Asthma		Nail Biting	
Bed wetting		Nightmares	
Bronchitis		Seizures	
Ear Infections		Sensory Defensiveness	
Epilepsy		Skin Problems	
Feeding Problems		Sleep Problems	
Gastrointestinal Problems		Visual Problems	
Headaches		Other	
Anxiety		Emotional Problems	

Please describe any allergies: _____
Does your child carry an EpiPen? Y/N

Does your child follow a special diet (gluten free, casein free)? Y/N If yes, please describe:
_____

_____

Does your child take any supplements or others special oils or herbs? Y/N If yes, please describe:
_____

List any other serious injury, surgery or hospitalization:

Incident	**Date**

List any medical precautions I should be aware of when working with your child:
_____

Please list any medications your child is currently taking:

Name of Medication	Dosage	Frequency	What Time of Day	Purpose of Medication

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Does your child have any past medication use? Y/N
If yes, what is the name of the medication, dosage, frequency and purpose?_____

Please check below if your child has been given any of the following medical diagnosis:

Diagnosis	X	Date
ADD		
ADHD		
Anxiety Disorder		
Asperger's Syndrome		
Autism		
Cerebral Palsy		
Cognitive Delay		
Diabetes Type I		
Down Syndrome		
Dyslexia		
Emotional Disorder		
Learning Disabilities		
Mood Disorder		
Orthopedic		
PDD		
Sensory Integration Dysfunction		
Other		

If boxes are checked above please list below the person who diagnosed and date of diagnosis:

_____

_____

Additional comments on your child's medical history: ___

_____

_____

Current Therapy:

Has your child ever had any previous Occupational Therapy Evaluations? Y/N
If yes, please list date and outcome: _____

_____

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Has your child ever seen, been assessed or evaluated by any of the following specialists:

Specialty	Yes / No	Assessment Date	Treatment Date	Other
Audiologist	Y/ N			
Chiropractor	Y/ N			
Developmental Pediatrician	Y/ N			
ENT	Y/ N			
GI	Y/ N			
Holistic	Y/ N			
Music Therapist	Y/ N			
Neurologist	Y/ N			
Nutritionist	Y/ N			
Ophthalmologist	Y/ N			
Optometrist	Y/ N			
Occupational Therapist	Y/ N			
Physical Therapist	Y/ N			
Psychiatrist	Y/ N			
Psychologist	Y/ N			
Special Educator				
Speech and Language therapist	Y/ N			

Day Care and Educational History:

Who cares for your child most of the time? _____

Does your child attend a: School_____ or Daycare _____

Please list Name of above school or daycare: _____

Please list Grade level if in school: _____ Teachers name: _____

If in preschool please list anticipated year to start kindergarten: _____

Please check type of classroom below:

Mainstream _____
Inclusion _____
Self-Contained _____

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Does your child go to:
Resource Room_____ if yes: For Subjects: _____
Has your child:
Skipped any grades _____ Repeated Grades _____

Does your child have an Individualized Education Plan (IEP)? Y/N
Does your child have a 504 plan? Y/N

Does your child have any social, emotional or academic difficulties in school? _____

_____

Please describe some of your child's gifts/strengths _____

_____

Does your child participate in any after school activities? Y/N If yes, please list_____
_____

What is your child's typical weekday after school schedule?_____

_____

What is your child's typical weekend schedule?_____

_____

Goals:
What are your goals for your child's program? Please be as specific as possible.

1. _____

   _____

2. _____

   _____

3. _____

   _____

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4. _____

_____

5. _____

_____

Please feel free to provide any additional comments below:

_____

_____

Name of Parent/Legal Guardian/Relationship to patient

_____

Signature: _____ Date: _____

Thank you again for completing this form!