Pediatric Therapy Services, Inc.
Making a difference . . . one child at a time.

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INTAKE QUESTIONNAIRE

Thank you for taking the time to fill out this questionnaire regarding your child. If you have any questions please call 507-388-5437. Thank you.

Name:_____ DOB:_____

Person completing this form:_____

Child's diagnosis (if applicable):_____

Diagnosis made by and diagnosis date:_____

Name of School or Daycare:_____

Please list any other special services your child receives:_____

Please describe your child's family/home life including those living in the home, siblings, pets, etc.:

_____

What are your child's strengths/interests?_____

What is your main concern? _____

Please indicate if your child has a history of any of the following:

	Yes	No		Yes	No
Was pregnancy full term?			Ear Infections?		
Any medications taken during pregnancy?			Ear tubes?		
Any complications with delivery?			Needs hearing aids?		
Any special care required at birth (i.e. oxygen, intubation)			Hearing evaluation completed? When?		
Any diagnosed genetic disorder?			Need for eye glasses?		
Is your child adopted?			History of car sickness?		
Frequent colds, respiratory infections, asthma or sinus problems?			Serious illness or injury?		
History of seizure(s)?			Any medical testing (i.e. MRI, EKG)?		

Please list current/regular medications:_____

Allergies/Precautions/Restrictions:_____

Does your child exhibit negative behaviors outside of those expected for his/her age? Please circle.

Refusal to do difficult tasks	Hitting or throwing items	Shutdowns
Tantrums	Difficulty separating	Refusal to imitate
Short attention	Other: _____	

Does your child have any behaviors that can put (him or her) or others at risk of injury? Yes / No

Please explain: _____

Does your child have a behavior plan? Yes / No

Speech and Language Questions

Child's name _____

Please circle the area(s) in which you have concerns?

Not Talking	Understanding directions	Ability to express themselves
Understanding what they say	Stuttering	Social Skills
Feeding	Oral Motor Skills	Auditory Processing

Speech:

Does your child use words to communicate? Yes/No

How much of the time do you understand your child's talking?

0-25% 25-50% 50-75% 75-100%

Do you understand more or less as sentence length increases?

Receptive Language:

Can your child point or touch a common object that you name? Yes/No

Does your child understand simple routine directions (i.e. sit down, come here, stand up)? Yes/No

Does your child follow multi-step directions (i.e. put on your pajamas, brush your teeth, and get a book)? Yes/No

Expressive Language:

Does your child try to gain your attention to show you or ask you for things? Yes/No

Circle the highest level in which your child is effectively communicating:

Gestures Words Phrases Sentences Conversation

Social Skills:

Is your child able to easily make/keep friends? Yes/No

Does your child initiate play with peers? Yes/No

Does your child use eye contact? Yes/No

Does your child take turns? Yes/No

Feeding/Oral Motor:

1. Does your child put toys/objects in his or her mouth? Yes/No
2. Does your child drool? Yes/No
3. Is your child a picky eater? Yes/No
4. Does your child cough when drinking or eating? Yes/No
5. Has your child had a video swallow study or been seen by another facility for feeding (i.e. Gillette, ISJ, etc.)? Yes/No

Do you feel your child eats a variety of foods in the following categories?

Meat: Yes/No Bread/starches: Yes/No Fruits: Yes/No Vegetables: Yes/No Drinks: Yes/No

Anything else you would like to share about your child's communication?

_____

_____

_____

My goal for my child's speech/language/feeding development is…

_____

_____

Occupational Therapy Questions

Childs name _____

Please circle any concerns you have about your child's development:

Overall Coordination	Independence with self-cares	Sensory Issues
Attention	Interaction with others	Play skills
Behaviors	Variety of foods accepted	Fine motor skills

Self Care skills:

1. Does your child need help with dressing? Yes/No
2. Can your child complete snap, zippers, and buttons? Yes/No
3. Can your child pick out his/her own clothing? Yes/No
4. Can your child feed him/herself independently? Yes/No Using fingers / spoon
5. Can your child drink from a cup? Yes / No Using bottle / sippy cup / straw / uncovered cup
6. Does your child typically take a shower or a bath?
7. Does you child know and follow morning or evening routines with few reminders? Yes/No
8. Does your child accept changes to daily routine without difficulty? Yes/No

Sensory:

1. How does your child respond to a change in environments such as going to school, or visiting friends or relatives? _____
2. Does your child respond negatively in busy environments such as grocery store or mall? Yes/No
3. Does your child seem unable to get enough stimulation? Yes/No
4. Are their certain types of sensory input that bother your child (clothing, tags, toothpaste, foods, grass, sand, swinging, sounds, etc.)? Yes/No Please explain:_____

_____

_____

Attention:

1. Does your child understand simple routine directions (sit down, come here)? Yes/No
2. Can your child follow multiple step directions (pick up your toys and put them away)? Yes/No
3. When looking at a book or pictures, do they show interest or interaction with story characters in the book? Yes/No
4. How long will they sit for a story? 5 min 10 min 15 min

Anything else you would like to share about your child's development?

_____

_____

_____

_____