KIDS DEVELOPMENTAL CLINIC
INTAKE / APPLICATION / REFERRAL FORM

Date of Intake: _____

Date of Order:_____ **Patient ID #:** _____

Patient Name: _____ **Date of Birth:** _____/_____/_____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:**_____ **Sex: M F**

Mother's Name: _____ **Fathers' Name:** _____

Guardian: _____ **Relationship:** _____

Work Phone: _____ **Alternate:** _____

Other Relative: _____ **Relation:** _____ **Phone:** _____

Insurance Company:_____ **Name of Insured:**_____

Address: _____ **Phone:** _____

Policy #: _____ **Group #:** _____

Social Sec (Insured's): _____ **Child's Social:** _____

Services Requested: ❑ **PT** ❑ **OT** ❑**ST**

Diagnosis:

1._____ **2**. _____
Date Date

3._____ **4.**_____
Date Date

Do you understand your child's diagnosis and prognosis? ❑**Yes** ❑ **No**

If No, what questions do you have? _____

Precautions/Contraindications:_____

Please list all known allergies: _____

Does your child have any food allergies? _____

Has anyone in your family been developmentally delayed? _____

How does your child communicate his/her wants or needs? _____
_____

_____

GENERAL INFORMATION

What languages does the child speak? What is the child's primary language? _____

_____

What languages are spoken in the home? What is the primary language spoken? _____

_____

Describe your concerns regarding your child's physical therapy (PT), occupational therapy (OT) and/or speech-language therapy (ST) needs: _____

_____

_____

_____

When was the problem first noticed? _____

Has your child received therapy in the past? If so, please let us know where services were received:

Therapy Agency: _____Services: _____Start Date:_____End Date:_____

Address: _____ City:_____ State: _____ Zip: _____

Phone: _____ Fax: _____ Therapist Name: _____

Therapy Agency: _____Services: _____Start Date:_____End Date:_____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Therapist Name: _____

FAMILY

Number of siblings: _____

Live in a ❑House ❑ Apartment: what floor ____ Stairs? ❑Yes ❑ No

With whom does the child live? _____

PRENATAL AND BIRTH HISTORY

Is child adopted? ❑Yes ❑ No

Is child in foster care? ❑Yes ❑ No

Mother's general health during pregnancy (illness, accidents, medications, etc.):_____

_____

_____

Mother's age at time of birth: _____ Number of Children: _____

Number of Pregnancies: _____ Did mother receive prenatal care? _____

Length of pregnancy (in weeks): _____

Circle type of delivery: Vaginal Caesarian

Birth weight: _____

General condition of child immediately following birth: _____
_____
_____

Was child in NICU or hospitalized? If yes, please explain. _____
_____

Please describe any unusual conditions that may have affected the pregnancy or birth.
_____
_____

MEDICAL HISTORY

Please provide the approximate ages at which the child suffered the following illnesses and conditions:

Headaches	**____**	**Frequent Colds**	**____**	**Ear infections**	**____**
Dizziness	**____**	**Allergies**	**____**	**Colic**	**____**
Convulsions	**____**	**Croup**	**____**	**Reflux**	**____**
Seizures	**____**	**Bronchitis**	**____**	**Kidney Disease**	**____**
Brain Injury	**____**	**Pneumonia**	**____**	**Lung Disease**	**____**
Encephalitis	**____**	**Asthma**	**____**	**Heart Disease**	**____**
Meningitis	**____**	**Aspiration**	**____**	**Skin Disease**	**____**
Chicken Pox	**____**	**Blindness**	**____**	**Other**	**____**
Measles	**____**	**Deafness**	**____**		
Mumps	**____**				

Has the child had any surgeries (e.g., tonsillectomy, adenoidectomy, etc,)? If yes, what type and when? _____
_____

Describe any major accidents or hospitalizations. _____
_____

Is the child taking any medications? If yes, name & dosage. _____
_____

Have there ever been any negative reactions to medications? If yes, explain. _____
_____

DEVELOPMENTAL HISTORY

Please provide the approximate ages at which child began to do the following activities:

Sit without help_____ Crawl _____ Walk_____

Use single words _____ Combine words _____ Feed Self _____

Bladder Control_____ Bowel Control: _____ Dress Self:_____

Are there/have there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe. _____
_____

Has there ever been a swallow study, GI testing? If yes, please describe the results._____

_____

What types of foods does your child prefer? _____

How many words does your child use in a sentence? _____ **If less than 50 words, what words do they use the most?** _____

Hearing Difficulty? _____
Has hearing been tested? ❑**Yes** ❑**No**
Results ? _____

Vision Difficulty? _____
Has vision been tested ? Yes ❑**No**
Results?

Behavior

What activities does your child enjoy? _____

What activities do you enjoy as a family? _____

In what skills does your child best excel/succeed? _____

What skills are most difficult for your child?_____

How does your child act at home?_____

How does he/she act at school? _____

How does he/she play with other children? _____

What is his/her attitude toward school? _____

Please circle any general difficulties your child is having:

Screaming	**Pinching**	**Overactive**	**Sitting still**	**Harming Self**
Attention	**Biting**	**Hitting**	**Bedwetting**	

Other _____

Please circle any adjectives that may describe your child:

Clumsy	**Agile**	**Risk Taker**	**Cautious**	**Affectionate**	**Distant**
Quiet	**Loud**	**Confident**	**Shy**	**Passive**	**Aggressive**
Outgoing	**Plays alone**	**Stubborn**	**Friendly**	**Impulsive**	**Picky eater**

Other Behavior/Psychological Concerns:
_____

Has your child undergone psychological testing? ❑**Yes** ❑**No**
Results? _____

Please list any additional comments about your child that you feel we should know:
_____

_____

_____

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CHILD'S EDUCATION

School: _____ **Phone:** _____
School District: _____ **Grade:** _____ **Teacher's Name:** _____
Is child currently enrolled in therapy, tutoring, or special education program? ❑**Yes** ❑**No**
If so, please indicate type of program/class : _____
Times child is available for Treatment: _____

Primary Physician: _____ **Specialty:** _____

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

Phone: _____ **Fax:** _____ **NPI #:** _____

(Please list all physicians your child sees)-If more room is needed please continue on back).
Consulting Physician: _____ **Specialty:** _____

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

Phone: _____ **Fax:** _____ **NPI #:** _____

Consulting Physician: _____ **Specialty:** _____

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

Phone: _____ **Fax:** _____ **NPI #:** _____

Equipment Supplier: _____ **Contact:** _____

Please List all Equipment (Wheelchair, Orthotics, and other Assisted Devices): _____

_____

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

Phone: _____ **Fax:** _____

Referred by: _____ **at** _____ **Phone:** _____