THE NEST

Child Intake Form / History

Today's Date _____

Client Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Diagnosis (if known): _____

Parent(s) / Guardians: _____

Address: _____

City, State, Zip: _____

Phone #1:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Phone #2:_____ ☐ Cell ☐ Home ☐ Work ☐ Other

Email #1:_____ Email #2: _____

Emergency Contact Name: _____

Emergency Contact Relationship to Child: _____

Emergency Contact (Information): _____

Client's Physician: _____

Physician Phone Number: _____

Physician Address: _____

Other Physicians / Specialists Involved In Care:

Referring Physician: _____ Phone Number _____

Physician Address: _____

How did you hear about The Nest Family Center?

_____

Family Background

Parent 1 Name: _____ Age: _____

Occupation: _____

Parent 2 Name: _____ Age: _____

Occupation: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

What adults does the child live with? Check all that apply:

☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)

☐Grandparent(s) ☐Both Parents ☐Parent 1 Only

☐Parent 2 Only ☐Other: _____

Does the child have siblings or are there other siblings in the home?

Child 1 Name: _____ Age: __ Sex: __ Speech Issues:_____

Child 2 Name: _____ Age: __ Sex: __ Speech Issues:_____

Child 3 Name: _____ Age: __ Sex: __ Speech Issues:_____

Child 4 Name: _____ Age: __ Sex: __ Speech Issues:_____

Child 5 Name: _____ Age: __ Sex: __ Speech Issues:_____

Language(s) spoken in the home: _____

Who speaks the other language(s)? _____

Describe the child's use/understanding of the language(s): _____

_____

Is there anything additional you would like to share about the family / home environment? _____

_____

_____

Evaluation

Briefly describe why you're seeking an evaluation by a occupational therapist at this time:
_____

_____

What are you expecting out of this evaluation / meeting? _____

_____

_____

Has the child had a previous occupational therapy treatment?

☐Yes ☐No By whom: _____When: _____

Describe the results: _____

_____

_____

Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons: _____

_____

_____

_____

_____

At what age did you first notice the problem? _____

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? ☐Yes ☐No

Describe: _____

2. Was there any stress during the pregnancy? ☐Yes ☐No

Describe: _____

3. Were there any complications during labor or delivery? ☐Yes ☐No

Describe: _____

4. What was the mother's age at the time of delivery? ____ years

Child's Health:

1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)

2. The child was _____ lbs ____oz and _____ inches at birth

3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section

4. Please describe any complications or concerns during labor or delivery:

_____

_____

_____

Check and describe all that apply:

☐ Adenoidectomy Describe: _____

☐ Asthma Describe: _____

☐ Behavior Issues Describe: _____

☐ Brain injury Describe: _____

☐ Breathing problems Describe: _____

☐ Cardiac issues Describe: _____

☐ Chicken pox Describe: _____

☐ Diabetes Describe: _____

☐ Ear infections Describe: _____

☐ Ear tubes Describe: _____

☐ Encephalitis Describe: _____

☐ Frequent colds Describe: _____

☐ High fever Describe: _____

☐ Measles Describe: _____

☐ Meningitis Describe: _____

☐ Mumps Describe: _____

☐ Seizures Describe: _____

☐ Sensory issues Describe: _____

☐ Sleep issues Describe: _____

☐ Tongue tie Describe: _____

☐ Tonsillitis Describe: _____

☐ Tonsillectomy Describe:_____

☐ Traumatic brain injury Describe: _____

☐ Vision issues Describe: _____

Is the child up to date with immunizations: ☐ Yes ☐ No

Please describe: _____

_____

_____

Has the child ever had surgery? ☐ Yes ☐ No

Please describe: _____

_____

_____

Has the child ever been hospitalized: ☐ Yes ☐ No

Please describe: _____

_____

_____

Has the child ever been in a serious accident? ☐ Yes ☐ No

Please describe: _____

_____

_____

Does the child have a chronic illness? If so, please describe: _____

_____

_____

Is the child currently on any medications? If so, please list medication name and reason for medication:

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

Does the child have any known allergies? ☐ Yes ☐ No

Describe: _____

_____

_____

Does the child currently use any equipment? (communication device, walker, etc.) Describe: _____

_____

_____

Does the child have a history of ear infections, tubes, etc. or use hearing aides? ☐Yes ☐No

Describe: _____

_____

_____

Does the child have any known hearing loss? ☐Yes ☐No

Describe: _____

_____

_____

If you have any concerns about the child's hearing, please describe: _____

_____

_____

Describe the child's current health status: _____

_____

_____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

☐Developmental Pediatrician _____

☐Neurologist _____

☐PT _____

☐OT _____

☐SLP _____

☐Behavioral Therapist _____

☐Educational Consultant _____

☐Psychologist / Psychiatrist _____

☐Vision Therapist _____

☐Other: _____

Developmental History

At what age did the child do the following:

Sit alone: _____ Crawl: _____

Stood Up: _____ Walk: _____

Made Sounds: _____ First Word: _____

Combined Words: _____ Sentences: _____

Fed Self: _____ Understood by Others_____

Toilet Trained: _____ Dressed Self: _____

Does the child do any of the following:

☐Choke on liquids ☐Choke on foods

☐Avoid foods ☐Maintain a special diet

☐Use a pacifier / suck thumb ☐Mouth objects

Please describe any of the above: _____

_____

_____

Does the child have any difficulty with the following:

☐Attention ☐Frustration Tolerance

☐Aggression ☐Anger

☐Answering simple questions ☐ Answering –wh questions

☐ Understanding people ☐ Following directions

☐ Excessive drooling ☐Chewing or eating

☐Producing speech sounds ☐Stuttering

☐Reading ☐School work

☐Remembering ☐Maintaining eye contact

☐Transitions ☐Word Retrieval

☐Other difficulties: _____

Please describe any of the above: _____

_____

_____

Has the child experienced any difficulty with feeding or swallowing? If so, please describe: _____

_____

_____

Educational History

Is the child currently enrolled in daycare/ school: ☐ Yes ☐ No

What is the name of the program? _____

What day(s) do they attend? _____

What is their grade level: _____

Type of classroom: _____

If they receive any accommodations, please describe: _____

_____

_____

Please describe any educational difficulties or learning challenges that this child has faced: _____

_____

_____

_____

Social History

Describe how the child interacts with parents, siblings, or other family members:

_____

_____

_____

Please describe the communication difficulties the child faces in the home environment: _____

_____

_____

_____

Describe any significant events or changes within the home: _____

_____

_____

What are the child's strengths? _____

_____

_____

_____

What are the child's weaknesses? _____

_____

_____

_____

What are the child's favorite activities? _____

_____

_____

_____

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? _____

_____

_____

Does the child become easily frustrated with certain activities? If so, please explain: _____

_____

_____

Describe how the child interacts with other children: _____

_____

_____

What are your goals for the child over the next 6 months? _____

_____

_____

_____

What are your goals for the child over the next 5 years? _____

_____

_____

_____

Is there anything else that is important for us to know about the child?

_____

_____

_____

_____

_____

_____

Person filling out the form: _____

Relationship to the child: _____