6215 Lorraine Road • Lakewood Ranch, FL • 34202 • (941) 758-4707

Parent/Client Intake Questionnaire

Child's Full Name: ____

Nickname: ___________________________ Date of Birth: ________________________

Gender (circle): Male or Female Age:___________________

Caregivers: ____ Phone # _________________

Address: ____ Email: ___________________

Name/Age of Sibling(s): ____

School/Daycare: ____ Grade: _____________

Medical History

Pregnancy Length (weeks): _____________ Delivery (circle): head-first, feet-first, C-section

Mother's health during pregnancy: ____

Pregnancy complications: ____

Does your child have any history of the following (Check any that apply):

____ear infections ____ear tubes ____strep
____skin problems/eczema ____difficulty sleeping ____dark circles under eyes
____loose stools ____constipation ____food allergies (list)
____difficulty breathing/asthma ____dental problems ____seizures
____feeding difficulties ____physical deformities ____refusal to eat/FTR
____poor attention/easily distracted ____frequent falls/poor balance

Comments: ____
____

Has your child had any of the following tests (Check any that apply):

____ vision screen/test date/results: _____________________________________

____ hearing screen/test date/results: _____________________________________

Primary Language spoken in the home: _______________ Secondary: ___________________

Hand Dominance (circle): right left

Developmental Milestones
At what age did your child do the following:

Sit: ____________ Crawl: _________ Feed Themselves: _________
Talk:____________ Walk: __________ Toilet Trained: ___________
Dressing: _______ Shoe-tying: ______

Did your child have difficulty with any of the following:

____sucking ____swallowing
____chewing ____changing to solid food

Is your child a picky eater? _______ If yes, what types of foods does s/he prefer?

____

Medications:____
____

Allergies:____
____

Communication (Please complete each skill that your child CAN do independently):
At what age did your child do the following:

Babble ____________ Understand speech ___________ Imitate sounds ____________

Say first word(s) _____________ Combined words ____________

Does your child:
____point to an item of interest ____bring an item to you for help
____label everyday objects ____combine two words (Mommy juice, go car)
____respond when name is called ____ask questions (what/where/who)
____use phrases appropriately ____use other's name to get attention
____greet others (hi/bye-bye) ____comment to another (Look, it's a ______!)
____ask for help ____answer by saying "yes" or "no"
____follow instructions ____understand what s/he is being told

Does your child echo or repeat words immediately after hearing them or at a later time?
____

Does your child repeat phrases from a favorite video/song/movie? ________________________

Is your child's speech easily understood by others? ________________________________

How many words does your child speak? ____

Pinnacle Pediatric Therapy
of Lakewood Ranch

6215 Lorraine Road • Lakewood Ranch, FL • 34202 • (941) 758-4707

Does your child understand what you say to him/her? ___________________________________

Did your child ever experience a loss or regression in his/her speech? ______________________

If yes, at what age did you notice this? ____

Behavior:

Does your child exhibit any of the following (Check any that apply):

____seem in his/her own world
____resistant to change
____excessive tantrums
____eats/chews on non-food items
____mood swings
____dislikes certain textures
____little or no sense of safety
____can't sit still (hyperactive)
____hurts self (bangs/hits head)
____non-compliance
____lack of respect for authority
____attached to unusual objects (stick, hair, string)
____difficulty transitioning
____aggression (hit, push, bite others)
____watches the same video repeatedly
____spins body or objects
____clumsy
____high pain tolerance
____climbs/jumps on furniture frequently
____seem to "space out" at times
____property destruction
____poor frustration tolerance

Does your child have a history of behavior problems in school? ____________________

Is your child's behavior different in certain settings or with certain people? ____________

____

Does your child become obsessive about one or several topics?
____

Does anyone in your family have a history of a condition which affected his/her development, ability to learn, or mental health? ____

____

Please list your primary concerns regarding your child's development:

____

____

Please list any community resources that your family is currently utilizing:

____

Please return to the office or therapist