New Client Intake Form

PERSONAL INFORMATION

Child's Name:_____ DOB:_____
Age:_____ Gender:_____
Mother/Legal Guardian Name:_____
Home Phone:_____
Cell Phone:_____
OK to leave message? Yes____ No____
Father/Legal Guardian Name:_____
Home Phone:_____
Cell Phone:_____
OK to leave message? Yes____ No____
DOB:_____
DOB:_____

Address where child lives:_____
Child lives with:_____
Current concerns bringing child to therapy:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____
Phone:_____

INSURANCE INFORMATION

Primary Insurance:_____ Policy Number:_____
Group Number:_____ Phone Number:_____
Insured's Name:_____ Insured's DOB:_____

Secondary Insurance:_____ Policy Number:_____
Group Number:_____ Phone Number:_____
Insured's Name:_____ Insured's DOB:_____
I DO NOT HAVE SECONDARY INSURANCE____

EMERGENCY MEDICAL RELEASE

In the event medical attention is required for your child while on the premises/during treatment of Spot It All Therapy, INC., parent/guardian authorization is required. Please read and sign statement below:

As legal guardian of _____, I give my permission for Spot It All Therapy, INC. to contact emergency personnel in the event of a medical emergency.

Parent/Legal Guardian Name:_____

Signature:_____ Date:_____

HISTORY

Prenatal

Pregnancy illnesses/complications/medications:

_____

_____

____Delivery: Vaginal____ C-section____

Born at how many weeks gestation:____

Complications/interventions at or after delivery:

_____

Developmental History

Sitting:_____

Crawling:_____

Walking:_____

First word:_____

Feeding

Feeding problems as an infant? If yes, please describe:

_____

Bottle or breastfed:_____

Difficulty transitioning to table foods? If yes, please describe:

_____

Medical History

Please describe your child's illnesses, hospitalizations, surgeries if there have been any:

_____

Allergies:_____

Medicine currently taking:_____

Current or past therapy interventions: _____

Hearing tested?: Yes_____ No_____ If yes, Pass_____ Fail_____

Vision tested?: Yes_____ No_____ If yes, glasses?_____

Education

Child attends:_____

Grade:_____

Does child have an IEP: Yes____ No____

Behavior
History of self-injury? If yes, please describe: _____
Difficulty with transitions: Yes____ No____
Engages appropriately with peers? If no, please describe:
_____

Language
What languages does the child speak? What is the child's dominant language?

What languages are spoken in the home? What is the dominant language spoken?

With whom does the child spend most of his/her time?

Describe the child's speech-language problem.

How does the child usually communicate (gestures, single words, short phrases, etc)?

When was the problem first noticed?

What do you think may have caused the problem?

How has the problem changed since it was first noticed?