

Pediatric Therapy Intake

Check boxes or use short answers. Skip what does not apply; "not sure" is okay.

Child And Household

Legal name _____ Goes by _____

Date of birth _____ Age _____

Address _____

City _____ State _____ ZIP _____

Child lives with _____ Home language(s) _____

Preferred language _____ Interpreter needed? ☐ Yes ☐ No

Parent Or Guardian And Contacts

Your name _____ Relationship to child _____

Phone _____ Email _____

Preferred contact ☐ Call ☐ Text ☐ Email Okay to leave voicemail? ☐ Yes ☐ No

Other parent or guardian _____ Phone _____

Emergency contact _____ Relationship _____

Emergency phone _____

Who may make medical decisions for this child? _____

Any custody or consent documents the office should review? ☐ Yes ☐ No ☐ Not sure

Insurance And Therapy History

Child's name _____ Date of birth _____

Insurance And Billing

Payment ☐ Insurance ☐ Self-pay ☐ Other _____ Bring insurance card(s).

Primary insurer _____ Plan _____

Member ID _____ Group number _____

Policyholder name _____ Date of birth _____

Relationship to child _____ Policyholder phone _____

Secondary insurance? ☐ No ☐ Yes → Insurer _____

Member ID _____ Group number _____

Policyholder _____ Date of birth _____ Relationship _____

Person responsible for billing _____ Phone _____

Billing address if different _____

Referred by _____ Primary care provider _____

Primary care office phone _____

Therapy And School Supports

Mark Past, Current, or both. Leave unused services blank.

Service	Past	Current
Occupational Therapy	☐	☐
Physical Therapy	☐	☐
Speech / Feeding Therapy	☐	☐
Counseling / Mental Health	☐	☐
Behavioral Services	☐	☐
Nutrition / Dietitian	☐	☐
Early Intervention / School Services	☐	☐

What helped most _____

School or childcare _____ Grade ____ ☐ IEP ☐ 504 ☐ IFSP ☐ None

Health And Medical History

Child's name _____ Date of birth _____

Check past or current concerns or diagnoses. You may attach a list.

Health History

- ☐ None known ☐ Not sure
☐ Premature birth / birth complications ☐ Developmental delay ☐ Genetic condition
☐ Autism ☐ ADHD / attention concerns ☐ Anxiety / mood concerns
☐ Seizures / neurologic condition ☐ Heart / breathing condition ☐ Asthma
☐ Muscle / bone / joint concerns ☐ Frequent pain ☐ Vision concerns
☐ Hearing concerns / ear infections ☐ Feeding / swallowing concerns
☐ Reflux / stomach concerns ☐ Constipation / bowel concerns ☐ Bladder concerns
☐ Sleep concerns ☐ Other _____

Key details / diagnoses / birth concerns _____

If premature, weeks early _____

Medicines And Allergies

Medicines or supplements ☐ None ☐ List attached ☐ Listed below

Name and reason _____

Allergies or reactions ☐ None known ☐ Not sure ☐ Listed below

Allergen and reaction _____

Surgery Hospital Stays And Safety

Surgeries or hospital stays ☐ None ☐ Not sure ☐ Yes → Brief reason and year

Anything we need to know for safe visits? ☐ No ☐ Yes ☐ Not sure

Examples: activity restrictions, seizure plan, choking risk, leaving safe areas, injury risk.

Details or plan _____

Equipment or supports ☐ None ☐ Glasses / hearing aids ☐ Braces / mobility device

☐ Communication device ☐ Feeding tube ☐ Other _____

Daily Life And Family Priorities

Child's name _____ Date of birth _____

Your Main Concerns

Your top 1-2 concerns and what you want to be easier for your child:

1. _____

2. _____

What helps or has been tried? _____

What does your child enjoy or do well? _____

A Typical Day

Weekdays mostly include ☐ Home ☐ Childcare ☐ School ☐ Other _____

Usual times: Wake _____ School / care _____ to _____ Bed _____

After school / daytime routine _____

Any routine that is especially difficult? _____

Sleep And Rest

Naps ☐ None ☐ Sometimes ☐ Most days Time _____ Length _____

Falls asleep easily ☐ Usually ☐ Sometimes ☐ Rarely ☐ Not sure

Stays asleep through the night ☐ Usually ☐ Sometimes ☐ Rarely ☐ Not sure

Night waking: _____ times; about _____ minutes awake in total.

Sleep concerns ☐ None ☐ Bedtime resistance ☐ Needs help to fall / stay asleep

☐ Snoring / breathing pauses ☐ Restless sleep ☐ Daytime tiredness

Sleep supports or other details _____

Eating And Drinking

Usual feeding ☐ Breast / bottle ☐ Table foods ☐ Tube feeding ☐ Other _____

Check concerns ☐ None ☐ Limited foods / textures ☐ Trouble chewing

☐ Coughing / choking with meals ☐ Gagging ☐ Long / stressful meals

☐ Appetite / growth ☐ Drinking enough ☐ Using cups / utensils ☐ Other _____

Diet needs, restrictions or helpful strategies _____

Play And Development

Child's name _____ Date of birth _____

Play And Community Activities

Where or how does your child play? Check all that apply.

- ☐ Home / backyard ☐ Playground / park ☐ Play café / indoor play ☐ Playdates
☐ Library / community group ☐ Sports ☐ Karate ☐ Gymnastics / dance
☐ Other _____ ☐ No regular activities right now

About how often outside home? ☐ Daily ☐ Weekly ☐ Monthly ☐ Less often

Favorite activities / programs _____

What makes joining in hard? ☐ Nothing ☐ Access / cost / schedule

- ☐ Movement ☐ Communication ☐ Sensory needs ☐ Behavior / emotions
☐ Other _____

Skills And Participation

Check concerns for your child's age or anything you want to discuss. Leave others blank.

- ☐ No concerns here ☐ Unsure what to expect at my child's age

Hands And Self-Care

- ☐ Grasping / using toys ☐ Drawing / writing / scissors ☐ Dressing / fasteners
☐ Toothbrushing / bathing ☐ Toileting ☐ Other _____

Movement And Coordination

- ☐ Sitting / crawling / walking ☐ Balance / falls ☐ Stairs / running / jumping
☐ Ball skills / playground play ☐ Strength / stamina ☐ Other _____

Speech And Communication

- ☐ Understanding words / directions ☐ Expressing needs / ideas ☐ Speech clarity
☐ Gestures / communication device ☐ Stuttering / voice ☐ Conversation / social play

Emotions And Behavior

- ☐ Worries / fears ☐ Sadness / withdrawal ☐ Big reactions / calming down
☐ Transitions / changes ☐ Attention / impulsivity ☐ Hitting / biting / self-injury

Any example or other concern _____

Sensory Experiences

Child's name _____ Date of birth _____

Check what you often notice or want to discuss. Consider your child's age.

☐ No sensory concerns ☐ Not sure

Smell

- ☐ Avoids foods, rooms, or people due to smells.
- ☐ Often sniffs toys, clothing, people, or objects.
- ☐ Misses strong smells that others notice.

Movement And Balance

- ☐ Avoids swings, slides, or feet off the ground.
- ☐ Wants to spin, swing, rock, or hang upside down.
- ☐ Climbs furniture or jumps from the couch.
- ☐ Wants faster, higher movement; hard to stop.

Body Pressure And Force

- ☐ Crashes into furniture or bumps into people.
- ☐ Wants tight hugs, squeezing, or firm pressure.
- ☐ Pushes, pulls, lifts heavy things, or squeezes hard.
- ☐ Uses too much force (tight hugs, broken toys).

Inside Body Signals

- ☐ Needs help noticing hunger, thirst, or fullness.
- ☐ Notices toilet needs late or after an accident.
- ☐ Very upset by hunger, warmth, or body feelings.
- ☐ May not notice pain, heat, cold, or feeling sick.

What brings this on or helps? _____

Other supports or family needs _____

Completed by _____ Relationship _____ Date _____

Sound And Hearing

- ☐ Avoids loud noises (vacuums, hand dryers).
- ☐ Bothered by background sounds (fans, voices).
- ☐ Makes loud sounds, hums, claps, or bangs objects.
- ☐ Misses being called or sounds others notice.

Sight And Light

- ☐ Squints, covers eyes, or avoids bright lights.
- ☐ Is bothered by visually busy places.
- ☐ Watches fans, spinning objects, lights, or patterns.
- ☐ Looks at toys up close or moves them near eyes.

Touch And Textures

- ☐ Bothered by tags, seams, socks, or fabrics.
- ☐ Avoids messy play; wants hands wiped.
- ☐ Avoids hugs, light touch, or unexpected touch.
- ☐ Often touches people, objects, or favorite textures.
- ☐ Upset by baths, nail trims, or brushing hair/teeth.

Taste And Food Textures

- ☐ Avoids mixed, lumpy, or crunchy food textures.
- ☐ Prefers bland foods; avoids strong flavors.
- ☐ Seeks strong flavors, such as sour or spicy.
- ☐ Chews or sucks clothing, toys, or nonfood items.