Patient Intake Form
Pediatric

Date: _____

Patient Name: _____ Date of Birth: _____

Parent / Guardian Names: _____

Address: _____
Street Address City State Zip

Phone #s: _____ _____
(Parent/guardian 1 home) (Parent/guardian 1 cell / work)

_____ _____
(Parent/guardian 2 home) (Parent/guardian 2 cell / work)

Email(s):_____

How did you hear about Arise Therapies, LLC? _____

Primary Care Provider (name and #): _____
Referred by PCP? ❑ Yes ❑ No

Primary insurance company: _____ ID #: _____

Primary insured name: _____ Relationship to patient: _____

Secondary insurance company: _____ ID #: _____

Secondary insured name: _____ Relationship to patient: _____

Number of siblings and ages: _____

School name: _____ Grade: _____

Has IEP? ❑ Yes ❑ No School SLP/OT/PT (name and #): _____

School Based Therapy: ❑ ST ❑ OT ❑ PT

Primary concerns today: _____

_____

_____

_____

Some of your child's favorite activities / play items: _____

_____

Patient Name: _____

Birth History

Born full term? ❑ Yes ❑ No If no, how many weeks? _____ Birth weight: _____

Please describe if any complications related to the pregnancy / birth: _____

_____

Developmental History

Please list the approximate age at which your child achieved the following developmental milestones:

Babbled: _____ Said first words: _____ Combined two words: _____

Crawled on all 4's: _____ Walked: _____ Toilet trained: _____

Self-fed with spoon: _____

What percent of the time is your child understood by family? ____% By an unfamiliar listener? ____%

Any concerns regarding fine motor skills? (i.e. drawing, cutting, writing, using utensils, buttons/zippers)

_____

Any concerns regarding dressing skills (i.e. getting dressed/undressed, buttons/snaps/zippers, shoe tying)?

_____

Any concerns regarding hygiene skills (i.e. tooth brushing, bathing, combing hair)?

_____

Has your child received any other evaluation or therapy (ST, OT, PT, vision, counseling, etc)? ❑ Yes ❑ No
Please briefly describe, including when and where:

Past services: _____

Current services: _____

Any relevant diagnoses: _____

Medical History

Recent hearing screening / test? ❑ Yes ❑ No ❑ Pass ❑ Fail

Any current concerns regarding hearing? _____

Has your child had any of the following?

❑ Adenoidectomy	❑ Ear (PE) tubes	❑ Sleeping difficulties
❑ Allergies	❑ Feeding difficulties	❑ Snoring
❑ Breathing difficulties	❑ Head injury	❑ Pacifier / thumb sucking habit
❑ Chronic cough	❑ Hoarse voice	❑ Tonsillectomy
❑ Ear infections	❑ Seizures	❑ Vision problems

Please list any other major hospitalizations / surgeries / medical concerns and approximate date(s):

_____

_____

Please list any medications your child takes regularly: _____

_____

Family History

Please list any relevant family history (speech/language/motor delays, learning difficulties, etc.):

_____

Sensory Motor Skills:

Please check any statements that describe your child:

_____ Frequently trips on his/her own feet

_____ Walks on his/her toes

_____ Frequently bumps into furniture, walls, or other people

_____ Seems unaware that face or hands are dirty (i.e. needs cues to wipe mouth)

_____ Has difficulty learning new motor tasks (i.e. jumping, catching a ball, jumping jacks, climbing, etc)

_____ Is in constant motion/has difficulty sitting still

_____ Chews on pens, straws, shirts, etc.

_____ Avoids touching certain textures (please list:_____)

_____ Avoids messy play (finger paint, playdough, mud, sand)

_____ Is sensitive to clothing tags or textures

_____ Has trouble falling asleep or staying asleep

_____ Dislikes having teeth/hair brushed

_____ Gets "stuck" on toy or task and has difficulty changing to another task

_____ Avoids/dislikes playground equipment (i.e. swings, ladders, slides, etc.)

_____ Difficulty with puzzles, copying shapes, and/or cutting, tracing, writing

_____ Difficulty accepting changes in routine

_____ Gets frustrated easily

Forms completed by: _____ Relationship to patient: _____