

**Pediatric Rehabilitation
Intake Questionnaire**

Today's Date _____/_____/_____

Child's Name _____ Age _____ Weight _____ Height _____ Dominant Hand: R or L

Physician who sent you here _____ Primary Care Physician _____

History

What is your chief concern(s)? _____

When did these issues start? _____

Was your child hospitalized or did they have surgery for this problem? Y N

What was the surgical procedure? Surgery Date _____/_____/_____

Does your child indicate or demonstrate signs of pain? Y N Explain: _____

If yes to the above question please rate: _____

Diagnostic Tests

What tests were done? None X-rays MRI CT scan Sleep Study Barium Swallow Study

What were the results? _____ Where was it done? _____

Please list dates of last hearing and/or vision tests: _____ Results: _____

Pregnancy/Delivery/Birth

Were there any complications or illness during pregnancy? Y N Explain: _____

Were there any complications during labor or delivery? Y N Explain: _____

If premature, how many weeks? _____ How many days did your child have to remain in the hospital after birth? _____

How much did your child weigh at birth? _____

If your child has a medical diagnosis, please specify _____

Developmental Milestones

Please note the approximate age your child achieved the following skills as able:

	Sitting	Belly Crawling	Crawling	Cruising along furniture	Walking	First words	Talking	Potty trained
Age:								

Social History

Please indicate age/sex of any siblings (i.e.4 y/o brother): _____

What is your child's birth order? _____ Please list number of adults living in the home _____

Does your child wear glasses? Y N How does your child learn best? Seeing Hearing Doing

How do you as the caregiver learn best? Seeing Hearing Doing

Name of school your child attends? _____ Grade: _____

Has your child ever received therapy or special services in the past? Y N Explain: _____

Feeding/eating

Was or is your child bottle or breast fed? _____

Were there any complications with feeding as an infant? Y N If No, explain: _____

Is your child using a sippy cup or regular cup? _____ Can they use hands and/or utensils to eat? _____

Sleeping

Is your child sleeping regularly through the night? Y N

Average time your child goes to bed _____ Average time your child wakes up _____

Sensory

Does your child tolerate changes in his/her schedule or routine? Y N _____
 Does your child tolerate different types or textures of food? Y N _____
 Does your child tolerate different types or textures of clothing? Y N _____
 What time of day is your child more attentive and/or alert? _____

Please note the approximate percentage of time your child spends in the following daily activities?

	Passive activities (i.e. TV)	Movement activities (i.e. playground)	Learning/interactive play
Percentage of time:	%	%	%

Medical History: Does your child have or has had any of the following medical conditions: (please circle Y or N)

Y N Jaundice
 Y N Infection at birth
 Y N Feeding problems at birth
 Y N Diabetes
 Y N Heart problems Explain: _____
 Y N Unexplained weight loss or gain
 Y N High Blood Pressure
 Y N Swallowing difficulty
 Y N Cancer: Type _____
 Y N Is the cancer in remission? Are they receiving treatment? _____
 Y N Thyroid Problem
 Y N Balance Problems/Falls
 Y N Seizures/Epilepsy
 Y N Stroke
 Y N Juvenile Arthritis
 Y N Asthma
 Y N Kidney Disorder

Allergies: Does your child have allergies to any of the following: (please circle Y or N and describe any reactions)

Reaction

Y N Latex _____
 Y N Adhesive tape _____
 Y N Wool _____
 Y N Chlorine based pool chemicals _____
 Y N Foods: Please specify _____
 Y N Medications: list _____
 Y N Other: _____

Please list your child's strengths and/or likes: _____

Please list your child's weaknesses and/or dislikes: _____

What are your goals for occupational/physical therapy? _____

Information provided by: Guardian/Parent Other: _____

Guardian/Parent Signature **Date** **Reviewed by therapist** **Date**