maple valley pediatric therapy

NEW PATIENT MEDICAL HISTORY INTAKE FORM

Child's Name:_____ Date of Birth: _____

_____

Primary residence *City* *Zip*

Age: _____ Gender: ☐ male ☐ female

Parent/Guardian: _____ Relationship _____

_____

Address- if different than child *City* *Zip*

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Preferred method of contact: _____

Parent/Guardian: _____ Relationship _____

_____

Address- if different than child *City* *Zip*

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Preferred method of contact: _____

Emergency Contact: _____ Relationship _____

Home Phone: _____ Cell: _____ Work: _____

Primary Care Physician:_____ Office Name: _____

Please list all current diagnosis (es): *(Leave blank if child has not been given a diagnosis)*

Diagnosis	Provider/clinic name	Date *(mm/yy)*

Reason seeking occupational therapy treatment: _____

_____

Please describe your child: _____

What are your child's strengths? _____

_____

What does your child dislike/have difficulty with? _____

_____

Please list any recreational activities and/or sports your child is involved in: _____

_____

_____

Please check each area of self-care tasks that your child completes independently.

	(check one)	*If you checked no, please explain level of assistance needed:*
Toileting	☐yes ☐no	
Brushing teeth	☐yes ☐no	
Washes hands	☐yes ☐no	
Baths self	☐yes ☐no	
Dresses self	☐yes ☐no	
Feeds self	☐yes ☐no	
Sleeps alone	☐yes ☐no	

Please list all family members that live with Child: *(excluding parents/guardians)*

Name	Relationship/Age	Name	Relationship/Age

Are there family members who have similar issues ☐yes ☐no *if yes, please explain:* _____

Primary language spoken at home: _____ Parents/Guardian Marital Status: _____

If divorced, please describe custody agreement: _____

Medically related problems during pregnancy and birth

Any complications during pregnancy? ☐yes ☐no if *yes, please explain:* _____

Any complications during/after birth ☐yes ☐no *if yes, please explain:* _____

Premature birth? ☐yes ☐no If yes, how early? _____ NICU stay? ☐yes ☐no If yes, how long? _____

Medically related problems of childhood

(Please check all that apply. For items checked "yes", please explain including if resolved or currently being treated)

Seizures	☐yes ☐no	
Asthma	☐yes ☐no	
Visual problems	☐yes ☐no	
Ear infections	☐yes ☐no	
Hearing problems	☐yes ☐no	
Sleep problems	☐yes ☐no	
Constipation/ diarrhea	☐yes ☐no	
Failure to thrive	☐yes ☐no	
Frequent headaches	☐yes ☐no	
Hospital admission	☐yes ☐no	
Surgery performed	☐yes ☐no	
Other	☐yes ☐no	

Please list allergies that your child has been diagnosed with

Allergen *(Tree nuts, penicillin, latex etc.)*	Severity *(mild to severe)*	Exposure Type *(check all that apply)*	Epi-pen/Inhaler? *(check one)*
		☐ ingested ☐ contact ☐ inhaled	☐ yes ☐ no
		☐ ingested ☐ contact ☐ inhaled	☐ yes ☐ no
		☐ ingested ☐ contact ☐ inhaled	☐ yes ☐ no
		☐ ingested ☐ contact ☐ inhaled	☐ yes ☐ no

Please list all currently prescribed medications for your child

Medication name	Dosage	Reason for use *(sleep, attention, mood, etc.)*

Please list all currently used over the counter medications, supplements, and/or vitamins

Product/brand name	Dosage	Reason for use *(sleep, diet support, etc.)*

Has your child had an occupational therapy evaluation within the last year? ☐ yes ☐ no

If yes, please contact our office. Many insurance companies generally allow only one OT evaluation per year. If may be possible to use current evaluation and proceed with therapy services.

Please check all <u>Non-School</u> based therapy services your child has participated in

☐ Occupational Therapy ☐ Speech-Language Therapy ☐ Physical Therapy ☐ ABA

☐ Mental Health Counseling ☐ Other _____ ☐ None

Please list where and when your child participated in above therapy services

Clinic or provider name	Therapy (OT, PT, SLP, etc.)	start-end dates (mm/yy - mm/yy)	presently attending?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Social Emotional Functioning

Does your child have trouble making friends? ☐ yes ☐ no Trouble keeping friends? ☐ yes ☐ no

Does your child have trouble calming themselves down when upset? ☐ yes ☐ no

What does a melt-down/tantrum look like? _____

What calms your child? _____

Education Information

School attending: _____ Grade level: _____

Teacher concerns: ☐ Motor skills ☐ Social abilities ☐ Self-help skills ☐ Learning abilities

Does your child have an IEP? ☐ yes ☐ no **Does your child have a 504 plan?** ☐ yes ☐ no

If yes to either of the above, please check all services received below and please bring copy of report to evaluation:

☐ Occupational therapy ☐ Physical therapy ☐ Speech therapy ☐ Hearing ☐ Vision

☐ Educational ☐ Behavioral ☐ Other_____

Other education experiences:

Pre-School? ☐ yes ☐ no Daycare? ☐ yes ☐ no

Please indicate if your child demonstrates any of the following behaviors frequently:

Cries often	☐ yes ☐ no	Dislikes playground equipment	☐ yes ☐ no
Frequent temper tantrums	☐ yes ☐ no	Seems to be "On the Go"	☐ yes ☐ no
Anxious	☐ yes ☐ no	Rocks self	☐ yes ☐ no
Trouble following directions	☐ yes ☐ no	Sensitive to light	☐ yes ☐ no
Trouble with changes in routine	☐ yes ☐ no	Sensitive to sound	☐ yes ☐ no
Clumsy /falls often	☐ yes ☐ no	Poor attention span	☐ yes ☐ no
Weak muscles	☐ yes ☐ no	Stutters	☐ yes ☐ no
Picky eater	☐ yes ☐ no	Able to talk but refuses	☐ yes ☐ no
Mouths objects	☐ yes ☐ no	Aggressive to others	☐ yes ☐ no
Dislikes tooth brushing	☐ yes ☐ no	Self-injurious behaviors	☐ yes ☐ no
Dislikes hair brushing	☐ yes ☐ no	Interacts well with peers	☐ yes ☐ no
Avoids touch from others	☐ yes ☐ no	Interacts well with adults	☐ yes ☐ no

Please describe your child's diet

Does your child have a history of early feeding problems? ☐ yes ☐ no

Does your child eat a variety of foods? ☐ yes ☐ no

Do you feel like your child's diet consists of a significantly limited amount of foods? ☐ yes ☐ no

Developmental skills

Please indicate the approximate age your child achieved each skill in the space provided below:

Sat alone _____ Crawled _____ Walked _____ Able to say a few words _____

Drank from a cup _____ Used a spoon _____ Pedaled a bicycle _____

Is there anything else you would like us to know? _____

_____

Name of person completing this form: _____ Relation to child: _____

Signature: _____ Date: _____