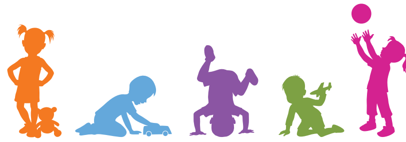

kids therapy made simple

Client Intake Form

This form is an interactive PDF; you can fill it out in Acrobat Reader. (If you don't have Reader, *download it here.*)

There are three ways to get the completed form back to us.

1. When you're finished, save your completed PDF and e-mail *info@ktms.us* with this document as as attachment.
2. Alternatively, you can save your completed PDF, and then click on the blue submission button on the last page, and follow the instructions Adobe gives you to send the document to us.
3. If for some reason you can't get the form to work, print it out, scan it (in PDF format, please), and then send it as an attachment to *info@ktms.us*.

GENERAL INFORMATION:

Name of person completing form: ______________________ date: ______________________

child's name: ______________________

date of birth: ______________________

gender: ☐ male ☐ female

pediatrician: ______________________

pediatrician phone number: ______________________

referred by: ______________________

primary language spoken at home: ______________________

name and ages of those living in the home: ______________________

____

____

parent name: ______________________

occupation: ______________________

parent name: ______________________

occupation: ______________________

home address: ______________________

____

home phone: ______________________

cell phone: ______________________

email address: ______________________

Kids Therapy Made Simple

phone: (310) 365-0500
web: www.kidstms.com

Dr. Lisa J. Lewis OTD, OTR/L MACLP
Doctor of Occupational Therapy / Master of Clinical Psychology

REASON FOR TODAY'S EVALUATION:

When did you first notice your child's difficulties and how did they become apparent to you?

____

____

Does your child attend daycare, school, or other program? ☐ yes ☐ no

If yes, where and when? ____

____

Has your child received previous evaluations or therapy? ☐ yes ☐ no

If yes, what kind, when and with whom? ________________________________

____

Is your child currently receiving other interventions or therapies? ☐ yes ☐ no

If yes, what kind, when, and with whom? _______________________________

____

Have there been any recent family stressors? Please check all that apply.

☐ marital separation /divorce ☐ death in the family ☐ financial crisis

☐ job change /difficulties ☐ school problems ☐ legal problems

☐ medical problems ☐ household move ☐ extended separation from parent(s)

☐ other stressful event (please describe) _________________________

____

____

How old was your child when s/he first:

rolled over: ____________________ sat independently: ____________________

crawled: ____________________ pulled to stand: ____________________

walked independently: ____________________ talked (single word): ____________________

spoke in sentences: ____________________

BIRTH HISTORY

Were there any complications during pregnancy? (e.g. illness, premature labor) ☐ yes ☐ no

If yes, please explain: ____________________

____

Did mother take any medication or drugs during pregnancy? ☐ yes ☐ no

If yes, what were they and why were they taken? ____________________

____

Did mother take any medication during delivery? ☐ yes ☐ no

Were there any complications during birth? Please check all that apply.

☐ premature birth ☐ breathing difficulty ☐ incubation

☐ jaundice ☐ transfusion ☐ forceps

☐ feeding difficulty ☐ suction ☐ congenital defects

☐ cesarean birth ☐ tube fed ☐ low APGAR

☐ other complication (please describe) ____________________

____

____

Where was your child born? ☐ hospital ☐ birthing center ☐ home

If hospital or birthing center, please name the facility: ______________________________

Term: __________ weeks Birth weight and length: ______________________________

Mother's age: ______________ Father's age: ______________ # days in hospital: ______________

Was your child in the NICU? ☐ yes ☐ no

If yes, why and for how long? ______________________________

____

The following are a list of infant behaviors? Please check all that apply to your child as an infant.

☐ cried a lot, fussy, irritable ☐ resisted being held ☐ good, non-demanding

☐ floppy when held ☐ alert ☐ tense when held

☐ quiet or passive ☐ very active ☐ liked being held

☐ good sleep patterns ☐ drooled excessively ☐ irregular sleep patterns

NUTRITIONAL HISTORY

☐ breast fed how long? __________ any difficulties? ______________________________

☐ bottle fed how long? __________ any difficulties? ______________________________

Did your child experience any of the following?

☐ colic ☐ food allergies

☐ growth/nutritional problems ☐ GERD

☐ other feeding problems: ______________________________

____

Age of transition to:

cereal: ____________________ solid: ____________________

finger foods: ______________ table food: ______________

Did your child experience any difficulties during these transitions? ☐ yes ☐ no

If yes, please explain: ____

____

Does your child use utensils? ☐ yes ☐ no

Did your child experience any feeding difficulties?

☐ spitting up ☐ refusal to eat ☐ sucking problems

☐ fussy eater ☐ overeating

☐ other feeding difficulties: ____

____

SLEEP PATTERNS

Does your child experience any difficulty falling asleep? ☐ yes ☐ no

What time does your child go to bed for the night? ____________________

What time does your child wake up in the morning? ____________________

Did your child sleep through the night? ☐ yes ☐ no

If no, how many times does s/he wake up during a typical night? ____________________

Did your child nap? ☐ yes ☐ no

If yes: how many naps per day?: ____________________

what time does your child go down for a nap? ____________________

how long does your child nap? ____________________

MEDICAL HISTORY

Did your child have any medical diagnoses? ☐ yes ☐ no

If yes, please explain: ____________________

____

Has your child had any of the following? Please check all that apply.

- ☐ frequent colds/respiratory illness
- ☐ frequent strep throat/sore throat
- ☐ birth defect/genetic disorder
- ☐ lung condition/respiratory disorder
- ☐ frequent ear infections (tubes?)
- ☐ allergies or asthma
- ☐ heart condition
- ☐ anemia/blood disorder
- ☐ kidney/renal disorder
- ☐ hormonal problem
- ☐ urinary problems/infections
- ☐ muscle disorder/problem
- ☐ joint or bone problem
- ☐ fractured bones
- ☐ skin disorder/problem
- ☐ visual disorder/problems
- ☐ eye infection
- ☐ neurological disorder
- ☐ seizures or convulsions
- ☐ stomach disorders
- ☐ vomiting/digestion problems
- ☐ failure to thrive
- ☐ feeding problems
- ☐ constipation
- ☐ diarrhea problems
- ☐ hearing loss/ear disorder
- ☐ significant accidents/trauma
- ☐ head injuries/concussions
- ☐ ingestion of toxins, poisons or foreign objects
- ☐ major medical procedures (please explain): ____________________

____

☐ medication taken for longer than 30 days/maintenance medications (please list medication, when taken and what was being treated: ____________________

____

____

☐ major childhood illness (e.g. chicken pox, foot and mouth, etc.): ______________________

____

☐ any hospitalizations (please list date and reason): ______________________

____

____

____

Is your child currently on any medications? ☐ yes ☐ no

If yes, please list medications and what they are treating: ______________________

____

Has your child had a hearing test? ☐ yes ☐ no

If yes, what were the results? ______________________

____

Has your child had an eye exam? ☐ yes ☐ no

If yes, what were the results? ______________________

____

Does your child wear glasses? ☐ yes ☐ no

SOCIAL / EMOTIONAL

What does your child enjoy doing? ______________________

____

Does your child become frustrated easily? ☐ yes ☐ no

If yes, what does s/he do? ____

____

How would you describe your child?

☐ outgoing ☐ shy ☐ easy to cry ☐ curious

☐ cheerful ☐ uninterested in environment ☐ difficult to soothe

☐ avoids group activities ☐ clingy ☐ easy to calm ☐ full of energy

☐ independent

Has your child ever had any difficulties with any of the following, beyond what is expected for a child's age?

☐ sleep problems ☐ bed wetting ☐ thumb sucking ☐ drooling

☐ temper tantrums ☐ head banging ☐ breath holding ☐ aggressive behaviors

☐ nervous habits ☐ masturbation ☐ major mood swings ☐ unusual fears

Does your child have friends? ☐ yes ☐ no

EDUCATIONAL HISTORY

Please only fillthis out if your child is attending preschool, kindergarten or elementary school.

name of current school: ______________________________

school address: ______________________________

phone number: ______________________________

teacher's name: ______________________________

Does your child have an Individualized Education Plan (IEP)? ☐ yes ☐ no

If yes, what services does s/he receive? ____

____

If your child is in private school, does s/he receive any Special Education Services? ☐ yes ☐ no

If yes, what services does s/he receive? ______________________________

____

Has your child's teacher shared any concerns with you regarding your child? ☐ yes ☐ no

If yes, please describe. ______________________________

____

Thank you!

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