Today's Date: _____

Pediatric Intake Assessment

***Please answer all questions as accurately and thoroughly as possible. Although some questions may not be applicable to you, there is a specific reason behind each question. This information will remain confidential at all times.**

General Information:

Patient's Name:_____ Date of Birth:__/__/____ Age:_____

Parents Name(s):_____

Referring Physician's Name:_____

How did you hear about us?:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Phones (please check box for best contact number):

☐ Home: _____ ☐ Work:_____ ☐ Cell:_____

Emergency Contact

Name:_____ Phone:_____ Relationship:_____

Name of your Insurance Carrier: _____

What is your greatest concern?:_____

When did you first notice these problems?:_____

What are your child's strengths?:_____

Getting to know your baby/toddler/child

The following questions help us to understand the strengths and concerns about your child, your needs, and aid us in determining effective treatment strategies.

Conception, Pregnancy, Labor, Delivery: Please check the answers that apply on the following questions:

- ☐ C – Section
- ☐ Cramping/Bleeding
- ☐ Extreme Morning Sickness
- ☐ Decreased intra – uterine movement
- ☐ Forceps
- ☐ Induced Labor
- ☐ Infections
- ☐ Less than average amniotic fluid
- ☐ Medical Assistance to Conceive
- ☐ Miscarriages/ Stillbirths
- ☐ Vacuum

Today's Date: _____

Feeing/Eating: If you have any concerns regarding your child's eating/feeding please check all that apply.

- ☐ **Difficulties Chewing**
- ☐ **Difficulty nursing from bottle or breast**
- ☐ **Food Aversions**
- ☐ **Grind Teeth**
- ☐ **Reflux**
- ☐ **Spitting or Throwing Up**
- ☐ **Require(d/s) medications for colic/reflux**

Sleeping: If your child has experienced sleeping difficulties, please check all that apply:

- ☐ Difficulty breathing through their nose
- ☐ Difficulty going to sleep
- ☐ Staying Asleep

Behavior: If you have any concerns regarding your child's behavior or tolerance to a variety of situations, people, sensory experiences, and play activities. Please check all that apply.

- ☐ Difficulties coping with parental requests more than other children their age
- ☐ Difficulty Interacting
- ☐ Eye contact
- ☐ Intolerance of certain movements or positions
- ☐ "Melt – Downs"
- ☐ More difficulty adjusting to new situations/people
- ☐ Tolerating different textures in food or clothing

Health: Does your child have any health problems, if so please check all that apply:

- ☐ Allergies/ Asthma
- ☐ Appears to be in pain
- ☐ Bad Falls
- ☐ Broken Bones
- ☐ Chronic Ear Infections
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diagnosed Disability
- ☐ Flat feet
- ☐ Headaches
- ☐ Medications
- ☐ Speech Delays
- ☐ Stomachaches
- ☐ Surgeries
- ☐ Toe – Walking
- ☐ Vision or hearing difficulties

Complains of pain in what areas:_____

Anything else that you feel we should know about your child:_____

_____

_____