Client Intake Form

Today's Date:___/___/___

Child's Name:______________________________

Child's Date of Birth:___/___/___ Age: ____

Male or Female

Home Address:____

Parent/Guardian name/s:____
Siblings Name and Ages: ____

Telephone:
Home:________________Cell:_____________________Work:________________
Home:________________Cell:_____________________Work:________________

Email:____

Email:____

Physician Name and Contact: ____

Please list any significant information in the following areas:

Prenatal and Birth History: ____

Family History: ____

Early Development including milestones: (rolling, crawling, walking)
____

Significant Medical History/Diagnosis:
____

Medications/Allergies: ____

Hospitalizations/Surgeries: ____

Parental Concerns: ____

Strengths: ____

Areas of Need: Check or circle and briefly describe

____Gross Motor:

___Balance ___Coordination __Bike __Body Awareness ___Posture on Floor/Chair

____Fine Motor:

___Grasp R/L ___Handwriting ___Cutting ___Utensils/Fasteners ___Coordination

____Self Help Skills:

___Dressing/Bathing/Grooming ___Feeding issues/Picky Eater ___Toileting ___Sleep

____Visual Perceptual/Motor Skills:

___Complete Puzzles ____Throw/Catch/Kick a Ball ____Build with blocks

____Sensory Processing:

___Sensory Seeking ____Does not like textures ___Sensitive to sounds/smells/tastes

___Overly active ___Clumsy ___Avoid having feet off ground ___Appears weak

___Speech

___Expressive language ___Receptive language ___Articulation ___Other

___Social Emotional

____Attention ____Play Skills ___Frustration tolerance

Likes: ____

Dislikes: ____

Past/Other Services: ____

Recent Vision Testing: _______ ____Eye Contact Wears Glasses: Y/N

Recent Hearing Testing: ________

Participation in Other Current Activities:

____

Name of Current School: ____

Grade:____________________________________

How Did you Find Us?___________________________________