



500 Chapman Street, Canton, MA 02021

Therapeutic Learning Center
781-821-9955

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INTAKE FORM

We encourage parents/caregivers to fill out this form together. Review the entire form before beginning. As this form is used for a wide range of ages and disabilities some questions may not apply to your child and you may skip those. Different opinions may be indicated by different marks or different color ink. If you have any questions or need assistance, please contact us.

I. GENERAL INFORMATION

Today's Date: _____

Child's Name: _____ Sex: Choose an item. Nickname: _____

Birthdate: _____ Age: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Person(s) completing form: _____ Rel. to Child: _____

Parents' Names: _____

Mother's Name: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mother's place of work: _____ Occupation: _____

Work Days/Hours: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Father's Name: _____ Home Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Father's place of work: _____ Occupation: _____

Work Days/Hours: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Parents' Marital Status: Married Never Married Sep/Div Widowed

Child lives with: Both parents Mother Father Other Adult (Specify) _____

Names and ages of siblings: _____

Child's Primary Language: _____ Language(s) Spoken at Home: _____

Teacher's Name: _____ Grade: _____

If in Pre-school, Pre-K or Kindergarten; Days and Times: _____

School: _____ Town: _____

Type of Classroom: _____

Does your child have an IEP? Choose an item. If yes, please attach copy of most recent IEP

Name of Insurance Company: _____

Name of Insured: _____ Insurance Number: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

List other professionals who have evaluated your child, any diagnosis made, and date:

II. PRESENTING CONCERNS

What prompted you to contact this clinic? _____

Are you looking for any particular services?

- Occupational Therapy
- Feeding Therapy
- Speech Therapy
- Therapeutic Listening
- Physical Therapy
- Bike Clinic

What are your main concerns about your child? _____

When were these problems first noticed? _____

What have you tried to do about these problems in the past? _____

What is your goal of this evaluation and/or treatment (i.e. independence with self care, increased peer interaction, independence on the playground, etc)? _____

III. PREVIOUS EVALUATIONS AND TREATMENT: please attach any written reports

Has your child ever been evaluated or treated at school or by other therapists? Indicate all that apply

Therapist	Eval	RX	Location	Dates
OT				
PT				
Speech Therapy				
Individual Therapy/Counseling				
Family Therapy				
Psychiatry				
Tutoring				
Neuropsychology				
Other				

IV. MEDICAL HISTORY

Has your child had any specialized medical tests performed? (e.g. EEG, MRI, Chromosome testing) _____

Has your child ever been hospitalized? _____

Is your child currently being treated for any medical condition(s)? _____

List any current medications and dosages: _____

Any allergies to medications? Please Specify: _____

Other allergies? Please Specify: _____

List any health precautions, limitations, or diet restrictions: _____

Does your child have any assistive devices (such as glasses, hearing aides, braces, wheelchair)?
If yes, please list: _____

Date of last Vision test: _____

Problems/Results: _____

Date of last Hearing test: _____

Problems/Results: _____

	Yes	No	Age +/-or Comments
Birth defects or birthmarks?	<input type="checkbox"/>	<input type="checkbox"/>	
Serious infections or illness (e.g. meningitis, mono)	<input type="checkbox"/>	<input type="checkbox"/>	
Head injury or loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent accidents or multiple injuries?	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting spells or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures, convulsions, or staring spells?	<input type="checkbox"/>	<input type="checkbox"/>	
Motor tics? (blinking, squinting, head tossing, etc)	<input type="checkbox"/>	<input type="checkbox"/>	
Vocal tics? (grunting, sniffing, throat clearing, noises)	<input type="checkbox"/>	<input type="checkbox"/>	
Compulsive mannerisms? (hand washing, picking, counting, touching)	<input type="checkbox"/>	<input type="checkbox"/>	
Motion sickness or carsickness?	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with kidneys, bladder, or urine?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood problems or anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
Poisoning or exposure to toxic chemicals (e.g. lead)?	<input type="checkbox"/>	<input type="checkbox"/>	
Unusual reaction to immunization?	<input type="checkbox"/>	<input type="checkbox"/>	
History or suspicion of physical or sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulties with eating, diet, or appetite?	<input type="checkbox"/>	<input type="checkbox"/>	
Small for age or underweight?	<input type="checkbox"/>	<input type="checkbox"/>	
Over eats or overweight?	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	Age +/-or Comments

Frequent headaches? Migraines?	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with vomiting, diarrhea, constipation?	<input type="checkbox"/>	<input type="checkbox"/>	
Any vitamin supplements? Please specify	<input type="checkbox"/>	<input type="checkbox"/>	
Any herbal medicines or other nutritional supplements?	<input type="checkbox"/>	<input type="checkbox"/>	
Any non-medical treatments? (diet, chiropractic, acupuncture)	<input type="checkbox"/>	<input type="checkbox"/>	

Birth History	Yes	No	Comments
Complications during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Prescribed bed rest?	<input type="checkbox"/>	<input type="checkbox"/>	
Spontaneous labor?	<input type="checkbox"/>	<input type="checkbox"/>	
Delivered at term (40 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	
Complications during labor?	<input type="checkbox"/>	<input type="checkbox"/>	
Complications during delivery?	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal delivery?	<input type="checkbox"/>	<input type="checkbox"/>	
Discharged with mother	<input type="checkbox"/>	<input type="checkbox"/>	
Passed all newborn screenings	<input type="checkbox"/>	<input type="checkbox"/>	
Birth weight:	<input type="checkbox"/>	<input type="checkbox"/>	

Developmental Milestones	Yes	No	Too Young/Comments
Sat up by 8 months	<input type="checkbox"/>	<input type="checkbox"/>	
Crawled by 10 months	<input type="checkbox"/>	<input type="checkbox"/>	
Walked by 15 months Age:	<input type="checkbox"/>	<input type="checkbox"/>	
Spoke 2 word sentences by 2 years	<input type="checkbox"/>	<input type="checkbox"/>	
Spoke understandably to strangers by 3 years	<input type="checkbox"/>	<input type="checkbox"/>	
Toilet trained during day by 3 ½ years	<input type="checkbox"/>	<input type="checkbox"/>	
Dry at night by 5 years	<input type="checkbox"/>	<input type="checkbox"/>	
Read simple words by 6 years	<input type="checkbox"/>	<input type="checkbox"/>	

Developmental Difficulties	Yes	No	Too Young/Comments
Urine accidents? Daytime or nighttime wetting?	<input type="checkbox"/>	<input type="checkbox"/>	
Stool/bowel accidents (soiling)?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty falling asleep or bedtime behavior?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty staying asleep or staying in bed at night?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty waking up in morning?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with self care (feeding, dressing, washing, toileting)?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty learning to button, zip, dress?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty learning to throw/catch a ball?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty learning to name colors or shapes?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty learning to name letters or numbers?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty learning to ride tricycle or bicycle?	<input type="checkbox"/>	<input type="checkbox"/>	

Current Developmental Skills	Above	Average	Below	Too
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	Average		Average	Young
Ability to understand spoken words (Receptive Language)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pronounces words clearly (Articulation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to talk and use good sentences (Expressive Language)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conversation Skills (turn taking, polite language)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to use fingers to write, draw, hold and move objects (Fine Motor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to use large muscles to run or play sports (Gross Motor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to make and keep friends (Social skills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments on development or skills: _____

V. BEHAVIORAL HISTORY

Describe any concerns that you have about your child's behavior: _____

What behavioral strategies do you use at home?

How does your child respond to being told "no" or being corrected?

How does your child respond to praise, rewards, or positive reinforcement?

Are there any differences between your child's behavior at home and school? _____

VI. SOCIAL HISTORY

Describe your child as an infant/toddler: _____

What is your child's temperament/personality like now? _____

How does your child get along with other members of the family? _____

How does your child get along with adults outside the family? _____

How does your child get along and play with peers/playmates? _____

Child's favorite toys, activities, sports, special interests: _____

How much time per day does your child spend watching TV? _____

How much time per day does your child spend on computer/video games? _____

Do you own a computer? No Yes

Does your child use a computer for schoolwork? No Sometimes Often

Does your child have Internet access? No Yes

VI. STRENGTHS AND ASSETTS

Each child is a very special person, with both strengths and weaknesses. It is very important that we focus on and capitalize on these strengths. Please describe what you feel your child's strengths are, the positive elements of their personality and character, and who your child is to you and your family.

Thank you for taking the time to complete this case history of your child, the information you have given will assist us in planning the most appropriate evaluations and interventions for your child. If there is additional information that you feel would be helpful or informative, please feel free to provide it below.

Please return this completed form to: Diane Maxson, MHA, MS, OTR/L

