



# Dynamic

# Therapy

FOR KIDS

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## INTAKE QUESTIONNAIRE

Patient's Name: \_\_\_\_\_

Today's date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Grade: \_\_\_\_\_

Cell phone: \_\_\_\_\_

School: \_\_\_\_\_

Email: \_\_\_\_\_

Siblings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What are your primary concerns and reason for referral? Please consider all areas of development that apply to your child, i.e. academics, self care skills, social relationships, sensory processing, fine and gross motor skills, and play skills.**

\_\_\_\_\_  
\_\_\_\_\_

**What are your child's favorite things to do and to play with? (hobbies, sports, toys)**

\_\_\_\_\_  
\_\_\_\_\_

**Has your child received a formal diagnosis?** Yes \_\_\_ No \_\_\_

Please list any diagnosis/date received: \_\_\_\_\_

\_\_\_\_\_

**Has your child received an recent evaluations or direct therapy services?**

Speech Y / N Provider \_\_\_\_\_ Date(s) \_\_\_\_\_

OT Y / N Provider \_\_\_\_\_ Date(s) \_\_\_\_\_

PT Y / N Provider \_\_\_\_\_ Date(s) \_\_\_\_\_

Other \_\_\_\_\_ Date \_\_\_\_\_

**Is your child being followed by any other medical professionals? (i.e. neurologist, psychologist, orthopedist) please list:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Developmental and Medical History

Please describe your child's birth history. List any complications during pregnancy, birth, and infancy. \_\_\_\_\_

What was your child's birth weight: \_\_\_\_\_

Any hospitalizations since birth? \_\_\_\_\_

Is your child adopted? Yes \_\_ No \_\_ Please describe circumstances surrounding the adoption: \_\_\_\_\_

Looking back at the first 2 years of your child's life, what type of baby was he/she? (feeding, sleeping, activity level, temperament?) \_\_\_\_\_

Please answer the following:

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Breastfed	_____	_____	_____
Bottle fed	_____	_____	_____
Specific health problems	_____	_____	_____
Thumb sucker/pacifier (until what age)	_____	_____	_____
Feeding problems	_____	_____	_____
Sleeping problems	_____	_____	_____
Colic or fussy baby	_____	_____	_____
Prefers certain positions (describe)	_____	_____	_____
Dislikes stomach	_____	_____	_____
Dislikes back	_____	_____	_____
Able to self soothe	_____	_____	_____
Mouthed toys	_____	_____	_____
On a regular schedule	_____	_____	_____
Enjoys bouncing	_____	_____	_____
Calmed by car rides or infant swing	_____	_____	_____
Becomes upset by car rides or infant swings	_____	_____	_____
Toe walker (until what age)	_____	_____	_____

Did your child have any illnesses, such as ear infections, tubes, respiratory problems, fevers, frequent colds? Please list. \_\_\_\_\_

Has your child had any difficulties with diarrhea, constipation, vomiting, headaches, or stomach aches? Please describe. \_\_\_\_\_

Does your child have any allergies? Please list. \_\_\_\_\_

Does your child currently take any medications? Please list and indicate for what conditions. \_\_\_\_\_

## Developmental Milestones

**Please give approximate ages if remembered, or comment on anything unusual.**

Rolled over _____	Walked _____	First words _____
Sat alone _____	Chewed solid food _____	First sentence _____
Crawled _____	Drank from a cup _____	

**How long did your child crawl?** \_\_\_\_\_

**Can your child go up and down stairs safely? Y / N    How?** \_\_\_\_\_

**Please describe if your child had any difficulties achieving motor milestones.** \_\_\_\_\_

**Please describe any developmental challenges your child has faced or continues to face.** \_\_\_\_\_

## Visual and Auditory Development

**Do you have any concerns about your child's vision?** \_\_\_\_\_ **What are they?** \_\_\_\_\_

**Has he/she had a vision exam?** \_\_\_\_ **When?** \_\_\_\_\_

**Does your child wear glasses?** \_\_\_\_\_

**Does your child do any of the following:**

close one eye or "wink" _____	trip/fall frequently _____
tilt head to one side _____	have difficulty reading _____
complain of headaches _____	avoid eye contact _____

**Do you have any concerns about your child's hearing?** Please explain. \_\_\_\_\_

**Has your child had a hearing test or screening?** What were the results? \_\_\_\_\_

**Does your child do any of the following:**

Cover his/her ears _____	confuses similar sounding words _____
Not respond to being called _____	get easily distracted _____
Avoid / "fall apart" in noisy environments _____	

## Speech and Language Development

**How would you describe your child's speech development?**

Normal \_\_\_\_\_ delayed \_\_\_\_\_ advanced \_\_\_\_\_

**Can you and others understand what your child is saying?** \_\_\_\_\_

**How does your child communicate?**

Gestures \_\_\_\_\_ single words \_\_\_\_\_ gestures and sounds \_\_\_\_\_  
gestures and words \_\_\_\_\_ phrases \_\_\_\_\_

**Describe any speech or language concerns or problems:** \_\_\_\_\_

**Is your child a picky eater? Y / N**      **Does your child have texture sensitivities? Y / N**

**Did your child have difficulty feeding as an infant (i.e tiring, trouble latching on, choking)**

**Please explain:** \_\_\_\_\_

**Does your child have any diet preferences?** \_\_\_\_\_

**How many words does your child have now? Please list** \_\_\_\_\_

\_\_\_\_\_

## Fine Motor Development

**Do you have any concerns about your child's fine motor skills? Please explain.** \_\_\_\_\_

**Do you have any concerns about your child's handwriting skills? Please explain.** \_\_\_\_\_

**Does your child have a hand preference?**

Right \_\_\_\_\_ Left \_\_\_\_\_ none \_\_\_\_\_

**Please check all that apply to your child:**

holds a pencil/ crayon well _____	able to manipulate objects _____
enjoys coloring _____	can use both hands together _____
able to snip with scissors _____	writes numbers and letters _____
able to cut paper _____	primarily scribbles _____
draws a picture _____	draws a person _____
picks up small objects with thumb and first finger _____	

## Self Care / Daily Routine

**Please describe your child's mealtime behavior and level of independence (what does he/she eat and / or avoid, what is your child's typical appetite, and behavior)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Does your child:**

eat with fingers \_\_\_\_\_ use a spoon \_\_\_\_\_ fork \_\_\_\_\_  
Drink from an open cup \_\_\_\_\_ sippy cup \_\_\_\_\_ Bottle \_\_\_\_\_  
How many/day? \_\_\_\_\_ Total number of ounces/day \_\_\_\_\_

**Please describe how your child gets dressed (types of clothes, cooperation, level of independence, behavior) \_\_\_\_\_**

**Does your child:**

Manage snaps \_\_\_\_\_ buttons \_\_\_\_\_ zippers \_\_\_\_\_ tie shoes \_\_\_\_\_

**Is your child toilet trained? \_\_\_\_\_**

**Please describe your child's sleep habits. Include bedtime routines, hard to fall asleep, difficult to wake, amount of sleep, naps. \_\_\_\_\_**

**Can your child make transitions between places or people? Please describe any routine needed to assist in transitions, ie objects, need for advanced warning, timers. \_\_\_\_\_**

**Social / Emotional**

**Does your child:**

Enjoy hugs and kisses \_\_\_\_\_ Enjoy interactive play with others \_\_\_\_\_  
Attempt to comfort others \_\_\_\_\_ Display wide variety of emotions \_\_\_\_\_  
Prefer to play alone \_\_\_\_\_  
Have frequent temper tantrums \_\_\_\_\_ If yes how many/day? \_\_\_\_\_  
How long do they last? \_\_\_\_\_ Is she/he able to calm themselves? \_\_\_\_\_

**Please describe your child's typical play skills. Include information such as ages of other children your child tends to play with, types of activities, ability to play with or near another child, ability to share or take turns. \_\_\_\_\_**

**Sensory and Motor Development**

**Describe your child's behavior on outings such as shopping, birthday parties, restaurants, family vacations. \_\_\_\_\_**

**Please check all that apply to your child:**

\_\_\_ My child seems *overly sensitive* to sensory experiences more so than other children his/her age:

Auditory \_\_\_\_\_ tactile \_\_\_\_\_ visual \_\_\_\_\_  
movement \_\_\_\_\_ taste \_\_\_\_\_ smell \_\_\_\_\_

\_\_\_ My child *doesn't* seem to react to sensory experiences as readily as other children his/her age.

Auditory\_\_\_\_  
movement\_\_\_\_

tactile\_\_\_\_  
taste\_\_\_\_

visual\_\_\_\_  
smell\_\_\_\_

\_\_\_ My child *seeks out* sensory experiences more so than other children his/her age.

Auditory\_\_\_\_  
movement\_\_\_\_

tactile\_\_\_\_  
taste\_\_\_\_

visual\_\_\_\_  
smell\_\_\_\_

\_\_\_ My child has difficulty differentiating sensory experiences (ex. Confuses sounds, can't find objects in a drawer or bag without looking, bumps into things).

Please describe: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ My child has trouble learning new movements.

\_\_\_ My child tends to be clumsy and has balance and coordination problems.

## School History

**Does your child receive special education services? Please include frequency of each (resource, speech therapy, OT, PT)** \_\_\_\_\_  
\_\_\_\_\_

**Is your child able to move around the school independently, tolerate noises in the cafeteria, attend assemblies, specials, and field trips?** \_\_\_\_\_  
\_\_\_\_\_

## Goals

**What do you see as your child's strengths?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are your goals for your child?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please feel free to share any additional information you feel would be helpful.**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for your time to help us better understand you child. We look forward to meeting you.*