Intake Form

PEDIATRIC THERAPIES (Outpatient) –Park Ridge

Date Completed: _____

Completed By: _____

Relationship to the child: _____

Type of Service requested: ___ OT _____ PT _____ ST _____VSS/BSS

(Previous Therapy/where?)_____

HAS YOUR CHILD BEEN SEEN IN OUR DEPARTMENT BEFORE? ___YES ___ NO

- **(For which therapy and when)_____**

PATIENT NAME: _____DOB: _____ M___F___

(UNDER 3 - REMEMBER TO INFORM OF EI)

PARENT/GUARDIAN NAME (RELATIONSHIP): _____

ADDRESS:_____

HOME #:_____ CELL #:_____ WORK #:_____

Why are you calling for a PT/OT/ST appointment? _____

_____

- **OT/ORTHO Upper Extremity – refer to Parkside.**

What are the things that are difficult for your child (symptoms)?_____

_____

Has your child been evaluated for this condition before? _____Yes _____No

If yes; when/where:_____

Please read what's on the order from the doctor (MED DX/FREQUENCY/EVAL-TX):

_____

DOES YOUR CHILD HAVE ANY OTHER MEDICAL OR DEVELOPMENTAL DIAGNOSIS? _____

WHO REFERRED CHILD? _____PHONE #:_____

PEDIATRICIAN: _____PHONE #: _____

INSURANCE: (if under 3, mention EI): ____HMO (ADVOCATE/referral in system?) ____HMO(OTHER/referral?) ___EI(have you talked to EI coordinator?) ___PA _____OTHER/PPO's

PREVIOUS HOSPITALIZATIONS RELATED TO THIS CONDITION/NICU: _____

_____

WHEN WAS CHILD DISCHARGED? _____

CURRENT OT/PT/ST SERVICES: _____

WHERE/HOW LONG? _____

PREVIOUS OT/PT/ST SERVICES: _____

WHEN/WHERE/HOW LONG (if within last 6 months – REPORTS):_____

If SCHOOL, then need IEP including goals & # of hours:_____

WHAT LANGUAGE(S) DO YOU SPEAK AT HOME? _____

WHAT IS THE CHILD'S PRIMARY LANGUAGE?_____

IF FEEDING OR VSS:

Does your child choke, cough, gag or vomit while eating? _____

Any specific foods your child has difficulty eating? _____

If under 12 months, what are your child's feeding times?_____

If under 12 months, was your child premature?_____How many weeks?_____

What type of seat does your child eat in? (highchair, your lap, bouncy seat, wheelchair, regular chair)

IF SPEECH/LANGUAGE EVAL:

What concerns do you have regarding your child's speech? _____

_____

Are there certain words or letters your child has difficulty with? _____

_____

How does your child communicate their needs? _____

_____

Has your child had a hearing test within the last 6 months?_____

If yes, do you know the results? _____

<u>OT</u>

If child is over age 2, please ask:

- **Has anyone mentioned sensory integration or sensory processing difficulties (i.e. difficulty with touch, movement or sound)? If yes, mail out sensory questionnaire and ask them to mail it back with the case history.**

Brachial/Plexus/Ortho/Post Operative Children:

- **Have physician state any precautions regarding range of motion, positioning, activity level and limitations or if now, have physician state "NO limitations of precautions" on orders.**

<u>PT/OT</u>

Patients with the following special circumstances will require an intake to be given to the team leader for scheduling:

- **Splinting**
- **Serial casting**
  - **Ask if Botox will be done; if yes is it scheduled yet? _____ When?: _____**
- **Aquatic therapy**
- **Post orthopedic surgery**
  - **Ask: Where was it done?_____**
    What was done? _____
    What frequency of therapy was recommended?_____
    If coming out of a cast; when? _____
  - **Acute hospitalizations:**
    - **Ask: What hospital? _____**
      When/Where: _____
- **Eval for Equipment?_____**