compleatKiDZ

Intake/Update of Information

FOR OFFICE USE ONLY ☐ New Intake ☐ Update of information

Child's Information

First Name _____ Middle Name/Initial _____ Last Name _____ Date of Birth ___/___/___

Gender ☐ Female ☐ Male

Residence Address _____

Primary Language _____

Current Concerns

Please describe the problems for which you and your child are seeking help

_____

_____

About when did these problems start?

_____

What do you hope therapy will accomplish?

_____

_____

Educational History

Current Placement

☐ Home ☐ Daycare - days per week: _____ ☐ Preschool - days per week: _____ ☐ Grade School

School Information ☐ *N/A - Not applicable*

School Name _____ Grade _____

TEACHER

First Name _____ Middle Name/Initial _____ Last Name _____

Phone Number _____ Email Address _____

PRINCIPAL

First Name _____ Middle Name/Initial _____ Last Name _____

Phone Number _____ Email Address _____

Individualized Education Program (IEP)?

☐ Yes ☐ Copy of IEP supporting document provided

504 Accommodations Plan?

☐ Yes ☐ Copy of IEP supporting document provided

Living Situation

☐ With Parents ☐ With Family ☐ With Friends ☐ Other _____

Parent(s)/Legal Guardian(s)

First Name _____ **Middle Name/Initial** _____ **Last Name** _____

Relationship to child
☐ Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Sister/Brother ☐ Foster Parent ☐ Court-Appointed Guardian

Phone Number _____ **Email Address** _____ **Primary Language** _____

Residence Address
☐ Same address as child

(if a different address) _____

First Name _____ **Middle Name/Initial** _____ **Last Name** _____

Relationship to child
☐ Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Sister/Brother ☐ Foster Parent ☐ Court-Appointed Guardian

Phone Number _____ **Email Address** _____ **Primary Language** _____

Residence Address
☐ Same address as child

(if a different address) _____

Emergency Contacts ☐ *N/A - Not applicable*

First Name _____ **Middle Name/Initial** _____ **Last Name** _____

Relationship to child
☐ Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Sister/Brother ☐ Foster Parent ☐ Family/Friend

Phone Number _____ **Primary Language** _____ **Permissions** ☐ Pick up ☐ Verbal info ☐ Written info

First Name _____ **Middle Name/Initial** _____ **Last Name** _____

Relationship to child
☐ Parent ☐ Grandparent ☐ Aunt/Uncle ☐ Sister/Brother ☐ Foster Parent ☐ Family/Friend

Phone Number _____ **Primary Language** _____ **Permissions** ☐ Pick up ☐ Verbal info ☐ Written info

Foster Care ☐ *N/A - Not applicable*

Agency Name _____

AGENCY CONTACT
First Name _____ **Middle Name/Initial** _____ **Last Name** _____

Phone Number _____ **Email Address** _____

General Health

Child's overall health is

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Allergies ☐ *N/A - No known allergies*

Needs EpiPen
☐ Yes

Seasonal Allergies
☐ Yes

Specific Allergies (list all known allergies) _____

Medications ☐ *N/A - Not applicable*

Specific Medications

_____

Pregnancy and Birth History

Length of pregnancy

☐ Full Term (37 wks+) ☐ Late Preterm (34-37 wks) ☐ Moderately Preterm (29-33 wks)
☐ Extremely Preterm (23-28 wks)

Child's birth weight

_____

Complications during pregnancy

☐ *N/A - Not applicable* ☐ *Yes (describe)* _____

Complications at birth/delivery

☐ *N/A - Not applicable* ☐ *Yes (describe)* _____

At birth:

☐ Jaundice ☐ Difficulty Breathing ☐ Required Oxygen ☐ Tube Fed ☐ Difficulty Feeding
☐ Placed in Incubator/Isolet ☐ Breast Fed ☐ Bottle Fed ☐ Strong Suck ☐ Frequent Spit-Up
☐ Passed Newborn Hearing Screen

In NICU:

☐ *N/A - Not applicable* ☐ *Yes (how long was the child in NICU?))* _____

Developmental History *Please check "Yes" if child is performing activity and age began, if known*

		Age			*Age*
Rolling Over	☐ Yes	_____	Initiating getting undressed	☐ Yes	_____
Sit without support	☐ Yes	_____	Initiating getting dressed	☐ Yes	_____
Crawling	☐ Yes	_____	Tie Shoes	☐ Yes	_____
Walking	☐ Yes	_____	Using single words	☐ Yes	_____
Running	☐ Yes	_____	Naming simple objects	☐ Yes	_____
Jumping	☐ Yes	_____	Combining words into phrases	☐ Yes	_____
Climbing Stairs	☐ Yes	_____	Asking/Answering questions	☐ Yes	_____
Pointing	☐ Yes	_____	Engaging in conversation	☐ Yes	_____
Clapping	☐ Yes	_____			

Oral Developmental *Please check, if applicable*

☐ Uses pacifier/sucks fingers or thumb ☐ Eats table food ☐ Drinks from an open cup
☐ Uses a straw ☐ Uses a spoon/fork to eat ☐ Gagging/Choking while eating
☐ Difficulty chewing ☐ Thickened liquids ☐ Picky Eater *(explain)* _____

Sleep

Describe child's sleep pattern

_____

Medical Conditions History

Medical Conditions *(Please check all that apply)*

Anemia	☐ Current	☐ Past	Impaired Coordination	☐ Current	☐ Past
Sexual Dysfunction	☐ Current	☐ Past	Infection	☐ Current	☐ Past
Anorexia/Bulimia	☐ Current	☐ Past	Intestinal Problems	☐ Current	☐ Past
Alcohol/Drugs	☐ Current	☐ Past	Joints Problems	☐ Current	☐ Past
Asthma	☐ Current	☐ Past	Kidneys Problems	☐ Current	☐ Past
Balance Problems	☐ Current	☐ Past	Lice	☐ Current	☐ Past
Bleeding	☐ Current	☐ Past	Liver Problems	☐ Current	☐ Past
Blood Transfusion	☐ Current	☐ Past	Loss of Consciousness	☐ Current	☐ Past
Bowel/Bladder	☐ Current	☐ Past	Lung Problems	☐ Current	☐ Past
Brain Injury	☐ Current	☐ Past	Macrocephaly	☐ Current	☐ Past
Breathing Problems	☐ Current	☐ Past	Memory Problems	☐ Current	☐ Past
Cancer	☐ Current	☐ Past	Microcephaly	☐ Current	☐ Past
Diabetes	☐ Current	☐ Past	Migranes	☐ Current	☐ Past
Digestive Problems	☐ Current	☐ Past	Movement Problems	☐ Current	☐ Past
Dizziness	☐ Current	☐ Past	MRSA	☐ Current	☐ Past
Ear Infections	☐ Current	☐ Past	Muscle/Weakness	☐ Current	☐ Past
Ear Tubes	☐ Current	☐ Past	Neuropathy	☐ Current	☐ Past
Endocrine Problems	☐ Current	☐ Past	Night Sweats	☐ Current	☐ Past
Eczema	☐ Current	☐ Past	Open Wounds	☐ Current	☐ Past
Enuresis/Encopresis	☐ Current	☐ Past	Pneumonia	☐ Current	☐ Past
Fainting	☐ Current	☐ Past	Seizures	☐ Current	☐ Past
Falls	☐ Current	☐ Past	Sexual Dysfunction	☐ Current	☐ Past
Fractures	☐ Current	☐ Past	Sickle Cell Anemia	☐ Current	☐ Past
Headaches	☐ Current	☐ Past	Sinus Problems	☐ Current	☐ Past
Hearing Loss	☐ Current	☐ Past	Skin Problems	☐ Current	☐ Past
Heart Problems	☐ Current	☐ Past	Thyroid Problems	☐ Current	☐ Past
High Blood Pressure	☐ Current	☐ Past	Vision Problems	☐ Current	☐ Past
Hepatitis B/C	☐ Current	☐ Past	Weight Change	☐ Current	☐ Past
HIV/AIDS	☐ Current	☐ Past		☐ Current	☐ Past

Other Medical Conditions *(Please specify)*

_____

Specialists Consulted in the last 12 months

☐ Orthopedist ☐ Cardiologist ☐ Psychologist/Psychiatrist ☐ Neurologist
☐ Geneticist ☐ ENT ☐ Gastroenterologist ☐ Other _____

Hospitalizations

☐ *N/A - Not applicable*
☐ *Yes (reason and age of child)*

_____

_____

Surgeries

☐ *N/A - Not applicable*
☐ *Yes (reason and age of child)*

_____

_____