



New Patient Intake Form

PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address:	City:	State/Zip:
School District:	School:	Grade:

PARENT/GUARDIAN INFORMATION		
Mother's Full Name:	Lives with Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address (if different):	City:	State/Zip:
Cell Phone Number:	Email:	
Father's Full Name:	Lives with Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address (if different):	City:	State/Zip:
Cell Phone Number:	Email:	

INSURANCE INFORMATION – Please select one: <input type="checkbox"/> Using Insurance <input type="checkbox"/> Self Pay		
Subscriber's Name:	Date of Birth:	Relation to Patient:
Insurance Company:	Insurance Phone Number:	
Policy Number:	Group Number:	Effective Date:
Secondary Insurance:	Insurance Phone Number:	
Policy Number:	Group Number:	Effective Date:

Who referred you to PerdueWorks Therapy Group?

MEDICAL INFORMATION	
Primary Care Physician:	Phone Number:
Please list any other specialists and office numbers:	
Please list any medical diagnosis/disability and date of onset:	
Immunization History: <input type="checkbox"/> Vaccinated on time <input type="checkbox"/> Delayed <input type="checkbox"/> Selective <input type="checkbox"/> Did not vaccinate	
Hearing: <input type="checkbox"/> Pass <input type="checkbox"/> Fail Date Screened:	*Current results required for speech testing
Vision: <input type="checkbox"/> Pass <input type="checkbox"/> Fail Date Screened:	
Does your child use any of the following? <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Cochlear Implant <input type="checkbox"/> FM System <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Standing Frame <input type="checkbox"/> Augmented Communication Device <input type="checkbox"/> Braces/Orthotics <input type="checkbox"/> Other (please list):	
Please list all medications and supplements your child currently takes (names and dosages):	
Does your child have any known allergies? If yes, please list and describe safety/emergency information (e.g., epi pens, inhalers, etc.): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child have seizures? If yes, please describe type and possible triggers (e.g., spinning, flashing lights, iPad, etc.): *If yes, please provide a copy of their formal seizure safety plan <input type="checkbox"/> Yes <input type="checkbox"/> No	
If your child has seizures, do they have a physician clearance for rotary input/spinning? Please list any additional medical/safety precautions or information: <input type="checkbox"/> Yes <input type="checkbox"/> No	

PRENATAL/BIRTH HISTORY:	MATERNAL CONCERNS/COMPLICATIONS:
Full Term Birth: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No Rash: <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre Term Birth: <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding: <input type="checkbox"/> Yes <input type="checkbox"/> No Fever: <input type="checkbox"/> Yes <input type="checkbox"/> No
Small for gestation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No Toxemia: <input type="checkbox"/> Yes <input type="checkbox"/> No
Forceps: <input type="checkbox"/> Yes <input type="checkbox"/> No	Trauma: <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Weight:	Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Length:	Infections: <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cesarean Section: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Planned <input type="checkbox"/> Emergency	Other:

NEONATAL/EARLY DEVELOPMENT:			
Appropriate HT/WT/Head Circumference:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did not like being cuddled:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory distress/oxygen:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive quietness:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypoglycemia/coma:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colic after 2 months:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Apnea/Seizures:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperactivity/Irritability:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaundice:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Altered sleep/wake cycles:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeding Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floppiness:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Passed newborn hearing/vision screening:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiffness:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other concerns:	Duration of hospital stay:		

MILESTONES :	
Indicate approximate age at which milestones were reached:	
Sitting unsupported:	Crawling:
Walking:	Talking (single words):
Talking (phrases/shortsentences):	Toilet training:

FAMILY HISTORY:
What languages are spoken at home?If multiple, please indicate which is their primary language:
Please indicate family history of the following: <input type="checkbox"/> Learningdisability <input type="checkbox"/> Languagedelays <input type="checkbox"/> ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Stuttering <input type="checkbox"/> Seizures <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Suicide <input type="checkbox"/> Other (pleaselist):
Please list names and ages of everyone living in the home with child (siblings, parents, grandparents, etc.):
Please indicate if any of the following circumstances occurred (which you believe may have affected your child’s development): <input type="checkbox"/> Divorce/separation <input type="checkbox"/> Deathof family/friend <input type="checkbox"/> Relocation <input type="checkbox"/> New baby <input type="checkbox"/> Illness/hospitalization <input type="checkbox"/> Other (please list):

THERAPEUTIC HISTORY:
Has your child received private or home health therapy in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list facility, duration of therapy, and type of service (e.g., “ABC Therapy – January 2020-December 2022 – OT/PT”)
Please list any additional private/home health therapy services that your child currently receives:

SPECIAL EDUCATION/504: *Skip this section if your child is not enrolled in public school*

Was your child ever tested for special education or 504 services? Yes No

Has your child met eligibility for special education or 504 services? Yes No

If yes, please complete the remaining boxes in this section

Please list disabilities and/or 504 eligibilities below (e.g., dyslexia, learning disability, speech impairment, etc.):

Please list type and frequency of services:

When was your child's most recent Full Individual Evaluation (typically administered every 3 years)?

When was your child's current IEP developed/last ARD meeting?

Please list any accommodations in your child's IEP or 504 plan that you would like your therapist to be aware of:

Is your child in a self-contained classroom? Yes No

Does your child have an accompanying Behavior Intervention Plan? Yes No

BEHAVIORAL INFORMATION:

Please list some of your child's interests (e.g., toys, characters, games, etc.):

Please list any items/activities that your child doesn't like or avoids:

Please indicate if your child exhibits any of the following behaviors:

- | | | | |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Poor focus/Attention | <input type="checkbox"/> Inability to sit still | <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Hitting/Kicking | <input type="checkbox"/> Throws objects | <input type="checkbox"/> Verbal outbursts | <input type="checkbox"/> Spitting |
| <input type="checkbox"/> Frequent tantrums | <input type="checkbox"/> Self-injurious behavior | <input type="checkbox"/> Difficulty with transitions | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Other (please list): | | | |

Do you notice an increase in problem behaviors when there is a change in routine? Yes No

Does your child engage in repetitive behaviors (e.g., hand flapping, spinning, etc.)? Yes No

If yes, please describe:

Does your child engage in unusual behaviors (e.g., lining objects, licking/sniffing items, holding objects in their hands, etc.)? Yes No

If yes, please describe:

Does your child receive ABA services or have they in the past? Yes No

If yes, please name facility/office and length of treatment: