Mankato Clinic
Pediatric Therapy Services

Patient Name:

DOB:

Date:

INTAKE QUESTIONNAIRE

Person completing this form: _____

If English is a second language, how long has your child been exposed to English: _____

Child's diagnosis (if applicable): _____

Who was diagnosis made by and diagnosis date: _____

Allergies/Precautions/Restrictions: _____

Current/regular medications: _____

Name of school and grade or daycare: _____

What are your child's strengths/interests? _____

Please indicate if your child has a history of any of the following:

	Yes	No		Yes	No
Was pregnancy full term?			Ear Infections?		
Any complications with delivery?			Ear tubes?		
Any special care required at birth (i.e. oxygen, intubation)			Hearing evaluation completed? When?		
Any diagnosed genetic disorder?			Need for hearing aids?		
Any significant current or past stress or trauma?			History of seizure(s)?		
Is your child adopted or in foster care?			Serious illness or injury?		
Frequent colds, respiratory infections, asthma or sinus problems?			Any medical testing (i.e. MRI, EKG)?		
Previous speech therapy treatment?			Need for eye glasses?		
Previous occupational therapy treatment?			Any surgeries? – If yes, please explain.		
Previous physical therapy treatment?					

Please indicate all of the area(s) in which you have concerns?

	Yes	No		Yes	No		Yes	No
Ability to express themselves			Gross motor skills			Sensory issues		
Attention			Independence with self-care			Social skills		
Auditory processing			Interaction with others			Strength/endurance		
Balance			Memory			Stuttering		
Behaviors			Not talking			Understanding directions		
Bowel/bladder control			Oral motor skills			Understanding what they say		
Coordination			Play skills			Walking pattern		
Feeding			Posture					
Fine motor skills			Reading and/or academic tasks					

Does your child have any behaviors that can put (him or her) or others at risk of injury? Yes / No

Please explain: _____

My goal(s) for my child based on my concerns are:

_____

_____

_____