kids therapy made simple

Client Intake Form

This form is an interactive PDF; you can fill it out in Acrobat Reader. (If you don't have Reader, *download it here.*)

There are three ways to get the completed form back to us.

1. When you're finished, save your completed PDF and e-mail *info@ktms.us* with this document as as attachment.
2. Alternatively, you can save your completed PDF, and then click on the blue submission button on the last page, and follow the instructions Adobe gives you to send the document to us.
3. If for some reason you can't get the form to work, print it out, scan it (in PDF format, please), and then send it as an attachment to *info@ktms.us*.

GENERAL INFORMATION:

Name of person completing form: _____ date: _____

child's name: _____ parent name: _____

date of birth: _____ occupation: _____

gender: ☐ male ☐ female parent name: _____

pediatrician: _____ occupation: _____

pediatrician phone number: _____ home address: _____

referred by: _____ _____

primary language spoken at home: _____ home phone: _____

name and ages of those living in the home: _____ cell phone: _____

_____ email address: _____

_____

Kids Therapy Made Simple

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REASON FOR TODAY'S EVALUATION:

When did you first notice your child's difficulties and how did they become apparent to you?

_____

_____

Does your child attend daycare, school, or other program? ☐ yes ☐ no

If yes, where and when? _____

_____

Has your child received previous evaluations or therapy? ☐ yes ☐ no

If yes, what kind, when and with whom? _____

_____

Is your child currently receiving other interventions or therapies? ☐ yes ☐ no

If yes, what kind, when, and with whom? _____

_____

Have there been any recent family stressors? Please check all that apply.

☐ marital separation /divorce ☐ death in the family ☐ financial crisis

☐ job change /difficulties ☐ school problems ☐ legal problems

☐ medical problems ☐ household move ☐ extended separation from parent(s)

☐ other stressful event (please describe) _____

_____

_____

How old was your child when s/he first:

rolled over: _____ sat independently: _____

crawled: _____ pulled to stand: _____

walked independently: _____ talked (single word): _____

spoke in sentences: _____

BIRTH HISTORY

Were there any complications during pregnancy? (e.g. illness, premature labor) ☐ yes ☐ no

If yes, please explain: _____

_____

Did mother take any medication or drugs during pregnancy? ☐ yes ☐ no

If yes, what were they and why were they taken? _____

_____

Did mother take any medication during delivery? ☐ yes ☐ no

Were there any complications during birth? Please check all that apply.

☐ premature birth ☐ breathing difficulty ☐ incubation

☐ jaundice ☐ transfusion ☐ forceps

☐ feeding difficulty ☐ suction ☐ congenital defects

☐ cesarean birth ☐ tube fed ☐ low APGAR

☐ other complication (please describe) _____

_____

_____

Where was your child born? ☐ hospital ☐ birthing center ☐ home

If hospital or birthing center, please name the facility: _____

Term: _____ weeks Birth weight and length: _____

Mother's age: _____ Father's age: _____ # days in hospital: _____

Was your child in the NICU? ☐ yes ☐ no

If yes, why and for how long? _____

_____

The following are a list of infant behaviors? Please check all that apply to your child as an infant.

☐ cried a lot, fussy, irritable	☐ resisted being held	☐ good, non-demanding
☐ floppy when held	☐ alert	☐ tense when held
☐ quiet or passive	☐ very active	☐ liked being held
☐ good sleep patterns	☐ drooled excessively	☐ irregular sleep patterns

NUTRITIONAL HISTORY

☐ breast fed how long? _____ any difficulties? _____

☐ bottle fed how long? _____ any difficulties? _____

Did your child experience any of the following?

☐ colic	☐ food allergies
☐ growth/nutritional problems	☐ GERD

☐ other feeding problems: _____

_____

Age of transition to:

cereal: _____ solid: _____

finger foods: _____ table food: _____

Did your child experience any difficulties during these transitions? ☐ yes ☐ no

If yes, please explain: _____

_____

Does your child use utensils? ☐ yes ☐ no

Did your child experience any feeding difficulties?

☐ spitting up ☐ refusal to eat ☐ sucking problems

☐ fussy eater ☐ overeating

☐ other feeding difficulties: _____

_____

SLEEP PATTERNS

Does your child experience any difficulty falling asleep? ☐ yes ☐ no

What time does your child go to bed for the night? _____

What time does your child wake up in the morning? _____

Did your child sleep through the night? ☐ yes ☐ no

If no, how many times does s/he wake up during a typical night? _____

Did your child nap? ☐ yes ☐ no

If yes: how many naps per day?: _____

what time does your child go down for a nap? _____

how long does your child nap? _____

MEDICAL HISTORY

Did your child have any medical diagnoses? ☐yes ☐no

If yes, please explain: _____

_____

Has your child had any of the following? Please check all that apply.

☐ frequent colds/respiratory illness ☐ frequent strep throat/sore throat ☐ birth defect/genetic disorder

☐ lung condition/respiratory disorder ☐ frequent ear infections (tubes?) ☐ allergies or asthma

☐ heart condition ☐ anemia/blood disorder ☐ kidney/renal disorder

☐ hormonal problem ☐ urinary problems/infections ☐ muscle disorder/problem

☐ joint or bone problem ☐ fractured bones ☐ skin disorder/problem

☐ visual disorder/problems ☐ eye infection ☐ neurological disorder

☐ seizures or convulsions ☐ stomach disorders ☐ vomiting/digestion problems

☐ failure to thrive ☐ feeding problems ☐ constipation

☐ diarrhea problems ☐ hearing loss/ear disorder ☐ significant accidents/trauma

☐ head injuries/concussions ☐ ingestion of toxins, poisons or foreign objects

☐ major medical procedures (please explain): _____

_____

☐ medication taken for longer than 30 days/maintenance medications (please list medication, when taken and what was being treated: _____

_____

_____

☐ major childhood illness (e.g. chicken pox, foot and mouth, etc.): _____

_____

☐ any hospitalizations (please list date and reason): _____

_____

_____

_____

Is your child currently on any medications? ☐ yes ☐ no

If yes, please list medications and what they are treating: _____

_____

Has your child had a hearing test? ☐ yes ☐ no

If yes, what were the results? _____

_____

Has your child had an eye exam? ☐ yes ☐ no

If yes, what were the results? _____

_____

Does your child wear glasses? ☐ yes ☐ no

SOCIAL / EMOTIONAL

What does your child enjoy doing? _____

_____

Does your child become frustrated easily? ☐ yes ☐ no

If yes, what does s/he do? _____

_____

How would you describe your child?

☐ outgoing ☐ shy ☐ easy to cry ☐ curious

☐ cheerful ☐ uninterested in environment ☐ difficult to soothe

☐ avoids group activities ☐ clingy ☐ easy to calm ☐ full of energy

☐ independent

Has your child ever had any difficulties with any of the following, beyond what is expected for a child's age?

☐ sleep problems ☐ bed wetting ☐ thumb sucking ☐ drooling

☐ temper tantrums ☐ head banging ☐ breath holding ☐ aggressive behaviors

☐ nervous habits ☐ masturbation ☐ major mood swings ☐ unusual fears

Does your child have friends? ☐ yes ☐ no

EDUCATIONAL HISTORY

Please only fillthis out if your child is attending preschool, kindergarten or elementary school.

name of current school: _____

school address: _____

phone number: _____

teacher's name: _____

Does your child have an Individualized Education Plan (IEP)? ☐ yes ☐ no

If yes, what services does s/he receive? _____

_____

If your child is in private school, does s/he receive any Special Education Services? ☐ yes ☐ no

If yes, what services does s/he receive? _____

_____

Has your child's teacher shared any concerns with you regarding your child? ☐ yes ☐ no

If yes, please describe. _____

_____

Thank you!

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Submit my responses.