SENSATIONAL KIDS, INC.

The Place For Pediatric Therapy

DEVELOPMENTAL INTAKE ASSESSMENT

Date:____________________

General Information:

Child's Name:____________________________________ Date of Birth:________

Parent's Names____

Child's Home Address: ____

Home Phone Number: ____

Best Daytime Telephone Number: ____

Medical History:

Is your child your birth child or specially chosen? (Circle One.) If not your birth child, please answer the following questions to the best of your knowledge.

Complications during labor and/or delivery? Yes or No (If yes, please describe)

Was child premature or full term (Circle One.)

Birth Weight: ______________ Apgar Score: _____________

Did your child have difficulty nursing or taking a bottle? Yes or No

Has your child had any hospitalizations and/or Surgeries? If so, please describe.

____

____

____

Has your child had any other health problems? If so, please describe.

____

____

Does your child take any medications on a regular basis? If so, for what reason?

____

____

Any side effects to medication noted? If so, what kind?___________________________

Does your child use any special equipment for daily activities, such as:

Glasses_____Hearing Aide_____Splints_____Walker_____Wheelchair_____

Is your child currently receiving other related services, such as speech or physical therapy? If so, please provide name of therapist and approximate date services began.

____

Has your child received occupational, physical, or speech therapy services in the past? If so, with whom and what were the approximate dates? __________________________

____

Referred by whom?____

Developmental History:

At approximately what age did your child do the following:

Sit independently	_________________	Walk independently	____________
Crawl on hands/knees	_________________	Say first word	____________
Talk in sentences	_________________	Undress self	____________
Dress self	_________________		

Can your child currently do the following with no assistance? (Answer Yes or No)

Sleep through the night regularly	_________	Finger feed self	____________
Drink from a regular cup	_________	Manipulate:	
Feed self with spoon/fork	_________	buttons	____________
Brush teeth	_________	zippers	____________
		shoelaces	____________

Additional Information:
Child's living environment includes the following people, if siblings, please include ages and sex:
____
____
____

Family Concerns and Goals, listed in order of importance: (What would you like your child to do that they can not do now.)
1. ____
2. ____
3. ____
4. ____

What are your child's favorite activities, things to eat, and/or cartoons, which can be used as motivators? (ex. Pokemon, Thomas the Train, Dora, goldfish, pretzels, Skittles)
____
____

What weekly activities does your child participate in regularly? (Ex. Soccer, church, gymnastics)
____
____

Social:
Is your child in school? Yes ___ No___ If yes, where? ________________________________
What grade?__________ Is child in any special classes or have special needs? ______________
Is your child's current symptoms interfering with social activities? _______________________
Does your child socialize with neighborhood children?______________________________
Does your child have a favorite friend at school or a small group of friends?________________
Would participating in a small occupational therapy group, to improve social skills, interest you?
Yes or No (circle one)

Billing Information:
Please contact our office at 405-840-1686 or by email at sensational.kids@hotmail.com for information regarding prices and reimbursement of occupational therapy and speech language therapy.

______________________________________Date________________________
Parent Signature