Asheville Community Therapy Center
959 Merrimon Avenue Suite 101
Asheville NC 28804
Phone (828) 417-7085
Fax (828) 417-7059

CHILD INTAKE FORM

To Parent/Guardian: Please answer the following questions about your child. **Please attach copies of the following documents:**

- Speech-language / Physical Therapy / Occupational Therapy evaluations, hearing tests, recent medical physical, and/or relevant medical evaluations (e.g., autism diagnosis).
- Goals that are currently/were previously targeted in therapy (including physical therapy, occupational therapy, or other speech services).

CHILD'S INFORMATION			
FULL NAME:		GENDER ☐ Male ☐ Female	DOB:
CURRENT AGE:	SCHOOL NAME AND GRADE IF APPLICABLE:		PREFERRED PRONOUNS (if applicable):
PRIMARY CARE PHYSICIAN (PCP):		PCP PHONE:	

DESCRIBE YOUR MAIN CONCERNS Include <u>when</u> the problem was first noticed, <u>who</u> noticed it, and <u>where</u> the problem occurs.	
How does your child react to the problem?	☐ Tries again/revises ☐ Becomes angry/frustrated ☐Other: ☐ Gives up ☐ Doesn't notice
Why are you seeking therapy services for your child?	
Has your child's physician noticed these concerns? If yes, what were his/her recommendations?	
How did you learn about us?	

In the table to the right, list all other services your child has received, including counseling; psychiatry; physical, occupational, or speech therapy. If none, check below.

☐ None

TYPE OF SERVICE	DATES/AGE	NAME OF PROVIDER

FAMILY'S INFORMATION

With whom does your child live? (Check all that apply)	☐ Biological parent(s)	☐ Adoptive parent(s)	☐ Legal guardian(s)
	☐ Grandparent(s)	☐ Sibling(s)	☐ Other:

In the table to the right, list all family members who live in the same home as your child.

NAME	AGE	RELATION TO CHILD

Do you have any family pets? (List name and type)

PARENT/CAREGIVER 1 INFORMATION

FULL NAME	GENDER ☐ Male ☐ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT ☐ PHONE 1 ☐ EMAIL ☐ PHONE 2	
PLACE OF EMPLOYMENT	PREFERRED PRONOUNS	

PARENT/CAREGIVER 2 INFORMATION

FULL NAME	GENDER ☐ Male ☐ Female	DOB
ADDRESS	CITY	ZIP
PHONE 1 ☐ CELL ☐ HOME ☐ WORK	EMAIL	
PHONE 2 ☐ CELL ☐ HOME ☐ WORK	PREFERRED METHOD OF CONTACT ☐ PHONE 1 ☐ EMAIL ☐ PHONE 2	
PLACE OF EMPLOYMENT	PREFERRED PRONOUNS	

Are there family circumstances that would be helpful to share with your child's therapist? (e.g., custody arrangements)	
Are there any other languages spoken in the home? If yes, which language(s) and how often?	

Do any other family members have communication, motor, sensory and/or related difficulties or disorders? (e.g., ADHD, autism)

RELATION TO CHILD	RELATED DIAGNOSIS/DISORDER

CHILD'S HEALTH BACKGROUND				
Describe your pregnancy, including any complications.				
Describe your labor/delivery, including any complications.				
TYPE OF BIRTH (check all that apply)	☐ Spontaneous (not induced)	☐ Induced	☐ Vaginal	☐ C-section
BIRTHPLACE (hospital/birth center)		BIRTH ATTENDANT (physician, midwife)		
GESTATIONAL AGE (in weeks)	BIRTH WEIGHT	BIRTH LENGTH	NICU ☐ Yes ☐ No How long?	
Were there any complications after birth or during the first few weeks?	☐ Difficulty breathing ☐ Difficulty feeding ☐ Birth defect ☐ Jaundice ☐ Seizures ☐ Other:			
Has your child's hearing been tested? ☐ Yes ☐ No If yes, when and where?			☐ Passed ☐ Did not pass	
Describe any serious illnesses, injuries, or medical procedures your child has experienced.				
List any environmental or food allergies.				
List any routine medications your child is currently taking or has taken long term.				
Describe any other conditions or diagnoses identified by your child's doctor or other professionals.				
CHILD'S STRENGTHS AND FAVORITES				
Describe your child's strongest skills and personality traits. What makes your child unique?				
FAVORITE ACTIVITIES / HOBBIES				
FAVORITE TOYS				
FAVORITE MOVIES				
FAVORITE BOOKS				

CHILD'S SENSORY NEEDS	
Does your child have any sensory needs that would be helpful for us to know? Please select all that apply.	☐ likes touch and hugs, enjoys tickles and light pressure ☐ is sensitive to sound or lights (circle one or both) ☐ doesn't like to be touched or hugged ☐ has intense interest in certain items or objects (specify) _____ ☐ has sensitivity to tastes, textures or smells (circle one or more) ☐ other, please explain _____ ☐ none / not applicable
If sensory needs are present, please help us know what would be best tolerated and what we should avoid.	☐ please avoid these items/things/activities: _____ ☐ please try to incorporate these items/things/activities: _____ ☐ other, please explain _____ ☐ none / not applicable
Please provide any further details that will help us understand your child's sensory needs. Feel free to continue on the back of this paper as needed.	

CHILD'S BEHAVIORAL NEEDS	
Does your child have any behavioral needs that require extra vigilance? Please select all that apply.	☐ PICA (ingesting non-food items) ☐ self-harm ☐ escape behaviors ☐ injury to family/teachers/therapists ☐ other, please explain _____ ☐ not applicable, my child does not have behavioral needs that require extra vigilance
If behaviors that are present require extra vigilance, would you like to be present in the room for therapy sessions?	☐ yes, I'd be more comfortable in the room ☐ no, I don't think I need to be in the room but will join sessions if asked to ☐ other, please explain _____ ☐ not applicable, my child does not have behavior needs that require extra vigilance
Please provide any further details that will help us understand your child's behavioral needs. Feel free to continue on the back of this paper as needed.	

CHILD'S FEEDING DEVELOPMENT ***COMPLETE FOR FEEDING/SWALLOWING EVALUATION/CONCERN ONLY***		
BREASTFED from _____ months until _____ months	FORMULA FED from _____ months until _____ months	BOTTLE until _____

At what age did your child begin using the following?	☐ SIPPY CUP _____ months ☐ STRAW _____ months ☐ OPEN CUP _____ months ☐ UTENSILS _____ months
Describe any difficulties with sucking, swallowing, chewing, eating different textures, etc.	

FAVORITE FOODS	FOOD AVERSIONS

CHILD'S SPEECH AND LANGUAGE DEVELOPMENT ***COMPLETE FOR SPEECH/LANGUAGE EVALUATION/CONCERN ONLY***	
At what age did your child begin:	☐ BABBLING (bababa) _____ months ☐ JARGON (bada bama) _____ months ☐ FIRST WORD_____ at _____ months ☐ TWO-WORD COMBO (more milk) _____ months ☐ THREE-WORD COMBO _____ months/years ☐ SENTENCES _____ months/years ☐ READING LETTERS _____ years ☐ WRITING LETTERS _____ years ☐ READING WORDS _____ years ☐ WRITING WORDS _____ years ☐ READING SENTENCES _____ years ☐ WRITING SENTENCES _____ years
Who understands your child's speech, and how much do they understand? 25% = 1 out of 4 words understood 50% = 2 out of 4 words understood 75% = 3 out of 4 words understood 100% = 4 out of 4 words understood	☐ Parent(s) _____% ☐ Sibling(s) _____% ☐ Peers _____% ☐ Teacher(s) _____% ☐ Extended Family _____% ☐ Strangers _____%
Has your child's speech-language been evaluated before? If yes, please note the place and summarize the findings.	
What are a few specific goals or skills you would like your child to attain in speech therapy?	
Is your child aware of his/her communication difficulties? Do you wish to share information with your child, such as goals or diagnosis?	

CHILD'S GROSS MOTOR DEVELOPMENT ***COMPLETE FOR PHYSICAL THERAPY EVALUATION/CONCERN ONLY****		
At what age did your child begin: (check all that apply)	☐ Rolling _____ months ☐ Sitting _____ months ☐ Crawling _____ months ☐ Standing _____ months ☐ Walking _____ months	☐ Climbing stairs _____ months / years ☐ Descending stairs _____ months / years ☐ Jumping _____ months / years ☐ Riding a tricycle _____ years ☐ Skipping _____ years
Does your child report / indicate pain?	☐ No ☐ Yes (please describe): _____	
Does your child use any medical equipment?	☐ Glasses / Contacts ☐ Hearing Aids ☐ Orthotics / Braces ☐ Stander ☐ Crutches	☐ Walker / Gait trainer ☐ Wheelchair ☐ Activity Chair ☐ Communication Device ☐ Bath Equipment	☐ Lift System ☐ Medical Bed ☐ Other: _____ ☐ None / Not applicable
Please provide any further details that will help us understand your child's gross motor needs. Feel free to continue on the back of this paper as needed.		

Thank you for taking the time to complete this form regarding your child.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE