Advanced Therapy of America

Speech Therapy, Feeding Therapy and Occupational Therapy

INTAKE FORM

Date: _____ /_____ /_____

Last Name: _____ **MI**: ___ **First Name:** _____

Nickname: _____

Date of birth: _____ /_____ /_____ **Age:** _____ **Sex:** **M** **F**

Location *(circle):* **ATA Iselin** **ATA Hoboken** **ATA Jersey City** **ATA Brooklyn**

Service *(circle):* **OT | Speech | OccuSpeech® | Feeding Therapy**

Home Address: _____

Medical Diagnosis *(if any):* _____

Allergies *(please list):*_____

Medications:_____

Medical precautions *(please be advised that written medical clearance may be required prior to initial consultation)*:

_____

What are your primary concerns regarding your child's development?

_____

_____

_____

_____

Who referred you to ATA?: _____

Caretaker 1:

Relationship: _____

Last Name: _____ **First Name:** _____

Occupation: _____ **E-mail:**_____

Home Phone Number: _____**Cell Phone Number**: _____

Caretaker 2:

Relationship: _____

Last Name: _____ **First Name:** _____

Occupation: _____ **E-mail:**_____

Home Phone Number: _____**Cell Phone Number**: _____

Siblings:

Name	Age	Will this sibling assist with bringing to therapy? *(Assisting with walking/transportation to ATA, English translation, etc.)*

BIRTH HISTORY

Conception: ☐ Normal ☐ IVF ☐ Hormone Therapy ☐ Other

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

Was the mother sick during pregnancy? ☐ Yes ☐ No

If yes to above question(s), please describe:

_____

_____

_____

How many months was the pregnancy? _____ **Was the birth induced?** ☐ Yes ☐ No

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If the child stayed in the hospital, please describe why and how long: _____

_____

What was the child's weight and general condition at birth? _____

Did the child have any difficulty with latching or feeding? _____

Was the child breast and/or bottle fed? _____

Was the child easy to sooth after birth? _____

MEDICAL HISTORY

Type of Doctor	Doctor's Name	Phone Number	Most Recent Appointment	Upcoming Scheduled Appointment
Pediatrician				

Please check the applicable medical history for your child:

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Breathing difficulties
- ☐ Chicken pox
- ☐ Colds
- ☐ COVID-19
- ☐ Ear infections
  - how often? _____
- ☐ Ear tubes
- ☐ Encephalitis
- ☐ Flu
- ☐ Head injury
- ☐ High fevers
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ RSV
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Sinusitis
- ☐ Sleeping difficulties
- ☐ Thumb/finger sucking habit
- ☐ Tonsillectomy
- ☐ Tonsillitis
- ☐ Vision problems

Does your child wear lenses?

☐ Yes ☐ No

Please list any additional medical procedures, surgeries, infections, or pertinent medical information:

_____

_____

DEVELOPMENTAL HISTORY

Please state the approximate age your child achieved the following developmental milestones:

- _____ Rolling
- _____ Sat up alone
- _____ Stood Up
- _____ Crawled
- _____ Walked
- _____ Babbled
- _____ Grasped crayon/pencil
- _____ Stopped using pacifier
- _____ Self-fed with utensils
- _____ Said first words
- _____ Spoke in short sentences
- _____ Toiled trained

ORAL MOTOR HISTORY

Does your child do the following?

- ☐ Choke on food or liquids?
- ☐ Put toys/objects in his/her mouth?
- ☐ Use a pacifier
- ☐ Suck his/her thumb
- ☐ Drink from a bottle
- ☐ Drool
- ☐ Allow toothbrushing?

Are you concerned with your child's nutrition or hydration? ☐ Yes ☐ No

What does your child typically eat/drink for:

Breakfast	Lunch	Dinner
Snacks:		
Drinks:		

Is your child a messy eater? ☐ Yes ☐ No **Can your child use a utensil appropriately?** ☐ Yes ☐ No

Do you consider your child a picky eater? ☐ Yes ☐ No

Are there any categories of food your child refuses to eat?

_____

SPEECH-LANGUAGE HISTORY

Language(s) spoken at home: _____

What is the primary language that you are using when communicating with your child?

_____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Do you believe that your child has any language difficulties (e.g., understanding, expression, vocabulary, sentence structure, ability to answer questions, etc.)?

_____

_____

Do you believe that your child has any speech difficulties (e.g., clarity of speech)?

_____

_____

Do you believe that your child has any oral motor difficulties (e.g., oral muscular strength)?

_____

_____

Do you believe that you child has any difficulties with socialization (e.g., interaction with others)?

_____

_____

Is your child aware of, or frustrated by, any speech/language/social difficulties?

_____

THERAPY HISTORY

Type of Therapy	Location	Phone Number	Dates	Skills addressed
e.g. OT	*ATA*	*212-991-0855*	*June 2016-January 2021*	*Fine motor skills, sensory processing*

CURRENT SPEECH-LANGUAGE SKILLS

Does your child…

- ☐ Imitate (e.g., if you clap your hands, will your child clap his/her hands to imitate you)
- ☐ Follow directions ("Get your shoes" or "Bring Mommy the ball.")
- ☐ Point to common objects during book reading ("Where is the ball, cup, shoe?")
- ☐ Repeat words after a model (e.g., Say apple→ apple)
- ☐ Respond correctly to yes/no questions?
- ☐ Respond correctly to who/what/where/when/why questions?

Your child currently communicates using:

- ☐ Body language/gestures
- ☐ Sounds
- ☐ Single Words
- ☐ 2-4 word combinations
- ☐ Sentences longer than 4 words
- ☐ Augmentative and Alternative Communication (AAC) device; Picture Exchange (PECS)
- ☐ Other _____

Behavioral characteristics:

- ☐ Cooperative
- ☐ Attentive
- ☐ Willing to try new activities
- ☐ Has a hard time with new activities/places
- ☐ Has separation difficulties
- ☐ Gets easily frustrated
- ☐ Stubborn
- ☐ Destructive
- ☐ Is always "on the go"
- ☐ Sits easily at a table to work/eat
- ☐ Has a limited attention span
- ☐ Can become aggressive
- ☐ Has self-injurious behaviors
- ☐ Has self-stimulatory behaviors
- ☐ Has repetitive behaviors

Eye Contact:

☐ Good ☐ Fair ☐ Poor

BACKGROUND INFORMATION

What motivates your child? *List preferred toys, games, activities, and interests below:*

_____

_____

_____

_____

Self-Help Skills:

	Independent	75%	50%	25%	Dependent	Additional Comments
Feeding						
Pullover shirt						
Pants						
Coat						
Socks						
Shoes						
Shoe tying						
Buttons						
Zippers						
Toileting						

Social-Emotional Behavior Characteristics:

Response to environment:

- ☐ Poor safety awareness
- ☐ Appropriate response to stimuli
- ☐ Appears unaware of objects
- ☐ Appears aware of objects
- ☐ Appears unaware of people
- ☐ Appears aware of people
- ☐ Brief eye contact
- ☐ Provides eye contact

Approach to task:

- ☐ Independent play
- ☐ Impulsive
- ☐ Says "I can't"
- ☐ Disorganized

Direction following:

- ☐ Follows verbal directions
- ☐ Follows visual directions
- ☐ Follows physical directions
- ☐ Unable to follow directions
- ☐ Follows 1 step directions
- ☐ Follows 2 step directions

Attention to task:

- ☐ Appropriate
- ☐ Distractible
- ☐ Not focused

Alertness:

- ☐ Engaged by environment
- ☐ Not engaged by environment

Transitions:

- ☐ Able to transition easily
- ☐ Unable to transition easily

My child's repetitive behaviors consist of: _____

_____

SCHOOL HISTORY

If your child is in school, please answer the following:

Name of school: _____ **Grade**: _____

Teacher's name: _____

Has your child repeated a grade? _____

What is your child's favorite subject? _____

Is your child having difficulty with any subjects? _____

Does your child have academic support? (i.e.IEP, 504 plan, tutoring, SEIT services, etc.)

_____

_____

Are there any other areas, besides academic subjects, that your child has difficulty with? (e.g. following directions, sitting at desk, making friends, etc.) _____

_____

ADDITIONAL COMMENTS

_____

_____

_____

_____