600 Waukegan Rd, Unit 132
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kidnectivity.org

Intake & Background Questionnaire

Patient Information

Child's Name_____

Date of Birth_____/_____/_____ Gender: Male Female

Home Phone _____ Social Security #_____

Address_____

City_____State_____Zip_____

Parent/Guardian Information

Mother's Name_____

Home Phone _____Cell Phone_____

Work Phone _____ Email _____

Address_____

City_____State_____Zip_____

Father's Name_____

Home Phone _____Cell Phone_____

Work Phone _____ Email _____

Address_____

City_____State_____Zip_____

Insurance Information

Primary Policy

Insurance Company_____

Address_____

City_____State_____Zip_____

Name of policy holder_____Relationship to patient_____

Policy holder's birthdate_____/_____/_____ Employer_____

Policy #_____Group #_____

Secondary Policy

Insurance Company_____

Address_____

City_____State_____Zip_____

Name of policy holder_____Relationship to patient_____

Policy holder's birthdate_____/_____/_____ Policy holder's Employer_____

Policy #_____Group #_____

*****Insurance is filed by this office as a courtesy to the patient. However, the patient is responsible for all fees, regardless of insurance coverage. It is the parent's responsibility to be aware of their benefits coverage.*****

_____

Signature Relationship to patient Date

Date_____/_____/_____

What are your primary concerns for having your child evaluated and treated?

_____

_____

_____

Medical Information

Primary Care Physician _____Phone #_____

Specialist/Other Physician_____Phone #_____

Specialist/Other Physician_____Phone #_____

Specialist/Other Physician_____Phone #_____

Diagnosis_____ Date of Diagnosis_____

Current Medications_____

Allergies_____

Family Information

Family members in the home_____

_____

Languages spoken in the home_____

Is there any known history of the following in the immediate or extended family?

(Please circle all that apply)

Autism/PDD ADHD Learning Disabilities

Hearing Loss Stuttering Speech/Language Delays

Caregiver Information

Caregiver Name(s)_____

Days/Times/Locations_____

Contact Phone Number(s)_____

Emergency Information

Emergency contact_____ Phone_____

Relationship to child_____

Pregnancy & Birth History

Did mother have any illnesses or complications during pregnancy or delivery? Yes No

Comments _____

Any medications, alcohol or other drug use during pregnancy? Yes No

Comments _____

At how many weeks was the child born_____ Birth Weight_____

Did child require hospital stay or time in NICU? Yes No

Comments _____

Did your child require any medical procedures before, during or after birth? Yes No

Comments _____

Were there any complication with bottle or breast feeding? Yes No

Comments _____

Was your child bottle fed or breast fed and for how long?_____

Did they have any colic or reflux issues? Yes No

Comments _____

Medical History

Has your child experienced any of the following? (Please circle all that apply)

Cleft Palate/Lip Seizures Frequent ear infections/fluid in the ears Reflux
Feeding Tube Gastroesophageal PE Tubes (if so, when?_____)

Please describe illnesses, medical issues, or hospitalization that your child has had and when.

_____

_____

Has your child's hearing been recently evaluated? Yes No

If yes, when, by whom and what were the results_____

_____

Is their vision within normal limits? Yes No

Has your child seen a specialist, or had other evaluations/testing?

_____

_____

Has your child received or is currently receiving other therapies?

_____

_____

Are there any other precautions we should know about that are not already described?

_____

_____

Developmental Milestones

Please note when each of the following occurred

Roll over_____ Crawl_____ Was crawling phase brief? Yes No
Walk_____Sit Up_____Drink from a cup_____Feed Self_____
Toilet Trained_____ Constipation or loose bowels? Yes No
What is the frequency of BMs?_____ Stomach aches? Yes No

Speech & Language Development

Please describe your child's primary mode of communication (gestures, signing, single words, short phrases, sentences, augmentative device, picture exchange)?_____

_____

If your child is talking, please indicate at what age your child began to:

Babble_____ 2-3 word phrases_____ First Words_____
Use language as primary mode of communication:_____

How much of your child's speech do you understand?

25% or less 25-50% 50-75% 75-100%

How much of your child's speech do others understand?

25% or less 25-50% 50-75% 75-100%

Are there specific sounds your child has difficulty saying?_____

Does your child demonstrate frustration when he/she is not understood? Yes No

If yes, please explain_____

Self Help

Please describe how much assistance does child needs for:

Eating_____

Dressing_____

Toileting_____

Bathing_____

Washing hands & face_____

Brushing teeth & hair_____

Behavior & Social Skills

Follows verbal directions	Yes	No	Comment:	
Initiates conversations	Yes	No	Comment:	
Makes eye contact when speaking	Yes	No	Comment:	
Has safety awareness	Yes	No	Comment:	
Is impulsive or a risk taker	Yes	No	Comment:	
Displays aggression toward self or others	Yes	No	Comment:	
Enjoys roughhouse play	Yes	No	Comment:	

Please describe your child's personality_____

_____

_____

What do you feel are your child's strengths?_____

_____

_____ _____

Does your child have tantrums? Yes No If yes, how often?_____

How do you handle discipline issues at home?_____

_____

_____

What are used for motivators or incentives for positive behavior at home or at school?

_____

_____

Does child tend to play alone or with others?_____

Daily Routine

What time does child go to bed on week nights?_____ Weekends?_____

Does child have difficulty falling asleep?_____

Does child wake during the night? Yes No If so, how often?_____

For what reason?_____

Does child tend to wake with difficulty or refreshed?_____

How well does your child handle transitions/changes in routine?_____

_____

What are child's favorite toys/activities?_____

_____

How well does your child organize/keep track of belongings?_____

_____

Eating & Diet

Is your child a picky eater?	Yes	No	Comment:	
Are they on a special diet?	Yes	No	Comment:	
Do they have any food allergies or intolerances?	Yes	No	Comment:	
Do you feel they get enough to eat and has a balanced diet?	Yes	No	Comment:	

Please explain what your child typically eats for meals throughout the day.
Breakfast_____
Lunch_____
Dinner_____
Snacks_____

Education
Name of School_____ Grade_____
Teacher_____Weekly schedule:_____
Type of classes Regular Special Education Life Skills Other
Do you have any academic concerns?_____
Is child satisfied with: School?_____Home?_____Friends?_____
If your child is not in school, where do they stay during the day?_____

What are your goals/what do you or your child hope to gain from therapy?_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this form!