



Apple Tree Therapy, LLC

Jackie Brown, OTR/L
Pediatric Occupational Therapist
9951 Mickelberry Rd NW, Suite 123
Silverdale, WA 98383
360-286-2351

INTAKE QUESTIONNAIRE

Child's First Name: _____ Middle Initial: _____ Last Name _____

GOALS

My primary area (s) of concern at this time (check all that apply):

- Sensory Processing Feeding Development Social/Emotional Functional Communication

Please describe, in your own words, what your current concerns for your child are at this time: _____

How can we be most helpful to you and your child? _____

What are your goals for your child:

In 1 month? _____

In 6 months? _____

In 1 year? _____

In 5 years? _____

MEDICAL HISTORY

Child's Primary Care Physician:

Name: _____ Profession: _____ Phone: _____

Address: _____

Date of Last Medical Checkup: _____ Height: _____ Weight: _____

Diagnosis: Please indicate any medical diagnosis or medical conditions below:

Medications: Please include prescription, homeopathic, over the counter and vitamin medications:

Allergies:

PREGNANCY HISTORY

Was the pregnancy for this child planned? Yes No

Did you have any problems getting pregnant? Yes No Comments: _____

In what month did you begin prenatal care? _____

Please list all medications taken during this pregnancy: _____

Did Mother have any of the following occur during this pregnancy?

YES	NO	Description	Explanation
		Allergy or Asthma	
		Anemia	
		Diabetes/blood sugar problems	
		Edema (swelling, water retention)	
		Excessive vomiting	
		Fatigue	

Did Mother have any of the following occurring during this pregnancy (cont.)			
YES	NO	Description	Explanation
		Accidents	
		Bleeding/spotting	
		Blood pressure problems	
		Blood transfusions	
		Headaches/migraines	
		Heart disease	
		Infections (bladder or genital)	
		Infections (other)	
		Kidney disease	
		Loss of a loved one	
		Other physical injury	
		Placed on bed rest	
		Pre-eclampsia	
		Pre-term labor	
		Rh negative	
		Severe stress	
		Shock	
		Toxemia	
		Toxin exposure	
		Use of drugs and/or alcohol	
		Uterine or uterine fluid problems	
		Other:	

BIRTH HISTORY

Hospital born: _____ City: _____ State: _____
 Was your child born: On time Early _____ weeks Late _____ weeks
 Length of labor: _____ hours Type of Delivery: Vaginal Cesarean Section (reason _____)
 Presentation: Head Face Breech Transverse
 Assistance: Forceps High Forceps Vacuum Suction Other _____
 Was there a positive bonding between mother and newborn at birth? Yes No
 What were the newborn's APGAR scores? 1 minute _____ 5 minute _____
 Birth weight: _____ Birth Length: _____
 Number of days spent in the nursery? _____ days NICU? Yes No _____ days
 Did mother experience any post-partum depression? Yes No

Did any of the following problems occur **during the labor/delivery**?

YES	NO	Description	Explanation
		Baby had cord wrapped around the neck	
		Baby had heart rate decelerations	
		Baby had very low or high heart rate	
		Cord problems (knots, prolapsed, compression)	
		Dysfunctional labor	
		Fetal distress was noted	
		Low or high blood cell count	
		Maternal infection	
		Merconium was noted	
		Pelvis or cervical problems	
		Placenta problems	
		Other:	

Did any of the following problems occur for **newborn following birth**?

YES	NO	Description	Explanation
		Anemia and/or transfusions	
		Brain hemorrhage	
		Cyanotic (was blue) at birth	
		Had bruising	
		Had tremors or seizures	
		Jaundice (yellow)	
		Required oxygen at birth	
		Required resuscitation	
		Required stimulation to breathe	
		Rh incompatibility problems	
		Very low muscle tone	
		Was considered small for gestational age	

Did any of the following problems occur for newborn following birth ?			
YES	NO	Description	Explanation
		Aspiration (meconium or fluid)	
		Choking or vomiting episodes	
		Congenital birth defects	
		Infections	
		Needed medications	
		Needed ventilation	
		Respiratory distress signs or syndrome	
		Tube feedings	

MEDICAL HISTORY OF CHILD

Does your child currently have or had a history of any of the following conditions, illness, or diagnoses?

YES	NO	Description	Comments
		ADD/ADHD	
		Allergies	
		Anemia/blood disorder	
		Anxiety disorder	
		Asthma	
		Autism Spectrum Disorder (ASD)	
		Birth defect/genetic disorder	
		Bone problem	
		Cognitive delay	
		Constipation problems	
		Dehydration episodes	
		Diarrhea problems	
		Down's Syndrome	
		Dyslexia	
		Ear disorder	
		Emotional disorder	
		Eye infections	
		Failure to thrive	
		Feeding problems	
		Fractured bones	
		Fragile X Syndrome	
		Frequent colds/respiratory illness	
		Frequent ear infections	
		Frequent strep throat/sore throat	
		Head injuries or concussions	
		Hearing loss	
		Heart condition	
		Hormonal problem	
		Ingestion of toxins, poisons, foreign objects	
		Joint problem	
		Kidney/renal disorder	
		Learning Disabilities (LD)	
		Lung condition/respirator disorder	
		Major childhood illnesses (e.g. croup, pox, measles, mumps, meningitis, etc)	
		Mood disorder	
		Muscle disorder/muscle problem	
		Neurological disorder	
		PE tubes placed	
		Seizures or convulsions	
		Sensory Processing Disorder	
		Significant accident/injury	
		Skin disorder/skin problems	
		Stomach disorder/stomach pain	
		Tourette's Syndrome	
		Urinary problems/infections	
		Visual disorder/vision problems	
		Vomiting/digestion problems	
		Weight problems	
		Other:	

Please list any hospitalizations your child has had and the reason. List the dates of any surgeries you child has had and the reason:

FAMILY HISTORY

Marital Status of Parents: Married (Date: _____) Divorced (Date: _____) Separated (Date: _____) Other _____
 What language(s) are spoken at home? _____

If both primary caregivers work, who cares for the child?

Name: _____ Relationship: _____ Avg time/day: _____

How would you describe your child's general adjustment at home? Poor Fair Good Excellent

How does your child get along with each member of the family?

Mother: _____

Father: _____

Siblings: _____

FAMILY STRESSORS (please note if any of the following stressful events happened in the **last 12 months**)

YES	NO	Event	Explanation
		Death in the family	
		Extended separation from parents	
		Financial crisis	
		Household move	
		Job change/difficulties	
		Legal problems	
		Marital separations/divorce	
		Medical problems	
		School problems	
		Other:	

Is there a family history of any of the following?

YES	NO	Event	Relationship to Child	Comments
		Left hand preference or ambidexterity		
		Learning difficulties		
		Behavioral challenges		
		Neurological concerns		
		Mental health concerns		
		Drug or alcohol abuse		
		Other:		

DEVELOPMENTAL HISTORY

What are your child's gifts/strengths? _____

What do you enjoy most about your child and family? _____

What kind of interests and activities does your child have? (i.e. hobbies, sports, clubs, favorite toys/games?) _____

Describe your child in the first two years of life. (i.e. feeding, sleeping, activity level, etc) _____

Describe your child in toddler stage _____

DEVELOPMENTAL MILESTONES:

Please indicate the age when your child first did each of the following INDEPENDENTLY.

Milestone	N/A	Early	On Time	Late	Age Achieved	Comments
Smiled						
Held head up						
Rolled over						
Reached for an object						
Transferred object between hands						

Please indicate the age when your child first did each of the following INDEPENDENTLY.

Milestone	N/A	Early	On Time	Late	Age Achieved	Comments
Sat unsupported						
Crawled						
Stood alone						
Walked by self						
Said first words						
Threw objects actively						
Ran by self						
Followed simple 1 step directions						
Said 2-3 word phrases						
Ate unaided with a spoon						
Dressed self						
Chewed solid food						
Drank from an open cup						
Rode bicycle without training wheels						
Caught a thrown object (ball)						
Demonstrated hand preference (which?)						
Knew colors						
Counted to 5						
Knew alphabet						
Bladder trained: days						
Bladder trained: nights						
Bowel trained						

Describe your tummy time experience with your child (i.e. tolerance, length of time, etc) _____

Describe your child's position with crawling (i.e. hands and knees), army crawl, scooted on bottom, etc) _____

AUDITORY:

Does your child have any problems with hearing? Yes No Comments: _____

When was the last time your child had their hearing tested? _____

COMMUNICATION:

Does your child have any problems with communication? Yes No Comments: _____

FEEDING:

Does your child have any problems with feeding? Yes No Comments: _____

MOTOR:

Does your child have any problems with gross motor movements? Yes No Comments: _____

Does your child have any problems with fine motor movements? Yes No Comments: _____

SELF CARE:

Does your child have any problems with self care tasks (i.e. dressing, bathing, eating, following daily routines)? Yes No
Comments: _____

SENSORY:

Does your child seem to be overly sensitive to sensory experiences more than others (over-reacts)? Yes No
Comments: _____

Does your child seem to be under sensitive to sensory input more than others (under-responsive or seeks out input)? Yes No
Comments: _____

Does your child seem to have difficulty learning new movements or tasks? Yes No

Does your child seem less coordinated than others? Yes No

VISION:

Does your child have any problems with eyesight or vision? Yes No Comments: _____

When was the last time your child had their vision tested? _____

ACADEMIC HISTORY

Describe your child's experience learning from preschool to present time _____

Name of Current School: _____ Grade: _____

Address: _____

Phone: _____ Teacher: _____

Describe any concerns shared by the teacher: _____

Does your child have an IEP in place? Yes No

BEHAVIORAL HISTORY

Do any of the following behaviors describe your child now or in the past?

YES	NO	Description	Explanation/Comments
		Able to self soothe when upset	
		Aggression	
		Any unusual fears	
		Bedwetting	
		Breath holding	
		Calmed by car rides or infant swings	
		Colic or "fussy" baby	
		Destructiveness	
		Disliked lying on back	
		Disliked lying on stomach	
		Enjoy bouncing	
		Excessive drooling	
		Extended separations in first 2 years	
		Fire play or cruelty to animals	
		Frequent Temper tantrums	
		Head banging	
		Major mood swings	
		Masturbation	
		Nauseated by car rides or infant swings	
		Nervous habits (i.e. nail biting)	
		Nightmares or night terrors	
		Preferred certain positions as an infant	
		Sleeping problems	
		Thumb sucking	
		Toe walker	
		Tolerate a regular schedule	
		Other:	

Describe a typical day for your child: _____

PREVIOUS TESTING and TREATMENT

Has your child ever been assessed, examined, evaluated or treated in any of the following areas?

	YES	NO	Start Date	End Date	Provider	Location
Academic						
Audiology						
Feeding						
Medical						
Psychological						
Occupational Therapy						
Physical Therapy						
Speech Therapy						
Other:						