Parent Intake Questionnaire

For admin use only:

TODAY'S DATE: ___________________

CLIENT INFORMATION

Name (first/last): ____________________________ **Gender:** ☐ **M** ☐ **F** **DOB (mm/dd/yy):** ______________

Referred By: ____ **Age (yrs/mo):** ________________

Services requesting or referred for:

☐ Social Group Therapy ☐ Individual Social Therapy
☐ Occupational Therapy ☐ Speech Therapy
☐ Evaluation ☐ Screening ☐ Consultation

Describe any general concerns you have regarding your child: _____________________________________

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PARENT/GUARDIAN INFORMATION

Primary Contact (first/last): ___________________________________ Relation to Client: _______________

☐ Cell: _____________ ☐ Work: ________________________ ☐ Email: ______________________________

Second Contact (first/last): ___________________________________ Relation to Client: _______________

☐ Cell: ______________ ☐ Work: ______________________ ☐ Email: _________________________________

Only list phone numbers where SBT may leave confidential voice messages, and check the box to indicate your preferred method(s) of contact.

Address incl zip: ____

List other caregivers that are permitted to participate in drop off, pick up, and wrap-ups:

Name: _________________________________ Phone: _________________ Relation: ________________

Name: _________________________________ Phone: _________________ Relation: ________________

BILLING INFORMATION *required*

*Email**:** ____ **all invoices are sent by email*

Address: _____________________________________City: ___________________ State: ______ Zip: ________

INSURANCE INFORMATION

Insurance Company Name/Ph Num: _______________________**Member ID#:** _________________________

Insured's Name and DOB: ________________________________

SCHEDULE AVAILABILITY

List, for each day of the week, the blocks of time you are **available** to participate in therapy. Write *NA* on days that will not work for you.

Hours of Operation:		Your availability
8am to 7pm	Monday	
	Tuesday	
	Wednesday	
	Thursday	
	Friday	
8am to 4pm	Saturday	

BIRTH HISTORY

Birth Weight: _______lbs. _______ oz. Number of days baby was in hospital after delivery: _______

Were there complications during (check all that apply):

☐ Pregnancy ☐ Delivery ☐ Post-Delivery OR ☐ Normal/ No Complications

If complications, briefly describe (e.g. weak suck nursing, vomiting, diarrhea, infections, low muscle tone):

____

FAMILY HISTORY/ENVIRONMENT

List language(s) spoken at home: ____

Child is: ☐ Biological ☐ Foster ☐ Adopted At what age? _____________

Child resides with (check all that apply):

☐ Biological Mother ☐ Foster Mother(s) ☐ Adoptive Mother(s)

☐ Biological Father ☐ Foster Father(s) ☐ Adoptive Father(s) ☐ Other:___________________

List sibling name(s), ages(s), and if they have medical, social, or academic concerns:

Name	Age	Concerns (if applicable)

List any family members who have medical, physical, speech/language, social, academic, or learning challenges:

Relation to Client	Concern(s)

MEDICAL HISTORY

History of medical concerns (check all that apply):

☐ Feeding Problems ☐ Eye Problems ☐ Head Trauma ☐ High Fever
☐ Tonsillitis ☐ Chronic Colds/Respiratory Infections ☐ Allergies ☐ Asthma
☐ Chronic Ear Infections ☐ Hearing Impairment ☐ Temporary Hearing Loss ☐ PE Tubes
☐ Other: ____

Diagnoses (e.g., autism, social anxiety, attachment disorder, attention deficit disorder, cerebral palsy, sensory processing disorder):

____

Pediatrician: ______________________________ last seen: ______________

Hearing test: ☐ Yes ☐ No If yes, when? __________________ results: __________________

Vision test: ☐ Yes ☐ No If yes, when? __________________ results: __________________

List current medications: ____

List food allergies/ dietary restrictions: ____

EDUCATION *If your child is not currently in school skip to CURRENT SERVICES section*

Current School/Day Care: ______________________________ District: __________________ Grade: ______

Type: ☐ Preschool ☐ Day Care ☐ Special Day Class ☐ Regular Ed ☐ Special Ed
☐ Other __________________________ ☐ Aide ___% of school day

How is your child's academic progress? ☐ Excellent ☐ Satisfactory ☐ Poor

List any concerns your child's teacher has expressed to you: ____

____

I give consent for Seven Bridges Therapy staff to speak with my child's current teacher. ☐ Yes ☐ No

Teacher (first/last): ______________________________ Phone: __________________

CURRENT & PAST SERVICES *If your child has never received therapy services skip to DEVELOPMENT section*

Please list all past and/or current therapy services your child has received, including previous SBT services.

Therapy Type & Location	Therapist (first/last)	Session Frequency	Last seen

SEVENBRIDGES THERAPY

Current Therapy Goals: ______________________________

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DEVELOPMENT

I've noticed my child has/is (check all that apply):

☐ Not cooing or babbling
☐ Frequent hospitalization
☐ Resistant to cuddling
☐ Difficult to calm
☐ Colicky
☐ Separation anxiety from a parent
☐ Avoiding eye contact
☐ Nonresponsive when spoken to
☐ Unusual play methods
☐ Not gesturing (e.g., waving bye-bye)
☐ Not pointing or requesting
☐ Restless
☐ Inactive
☐ Difficulty sharing
☐ Difficulty sleeping
☐ Difficulty eating

Did your child reach the following milestone at the typical age?

Milestones	**Age in months**	**Yes**	**No**	**If No, then at what age?**
Pointed	6 – 9	☐	☐	________
Sat without support	6 – 8	☐	☐	________
Crawled	8 – 13	☐	☐	________
Walked with assistance	12 – 15	☐	☐	________
Spoke first words	12	☐	☐	________
Spoke in 2 - 3 word sentences	18	☐	☐	________
Potty trained during day	24 – 36	☐	☐	________
Graduated from bottle	12-24	☐	☐	________
Stopped using pacifier	12-24	☐	☐	________

Does your child (check all that apply):

☐ Repeat sounds, words, or phrases over and over
☐ Follow simple directions
☐ Understand what you are saying
☐ Retrieve/point to common objects when requested
☐ Respond correctly to who/what/when questions
☐ Respond correctly to yes/no questions

How does your child currently communicate?

- ☐ Body Language
- ☐ Sounds (vowels, grunting, gurgling)
- ☐ Single words (shoe, doggy)
- ☐ 2 - 4 word sentences
- ☐ Sentences longer than 4 words
- ☐ Eye gaze
- ☐ Facial expression
- ☐ Signs/pictures

At what age did you first become concerned about your child's physical, speech, language, and/or communication skills and why?

____

Describe your child's temperament and activity level:

____

In order to provide our therapists with a complete profile of your child's strengths and challenges, please check all that apply:

Social Communication/Cognitive Skills	Often	Sometimes	Rarely
Avoids or shows no/little interest in social interactions of same-age peers	☐	☐	☐
Needs to be directly taught "implied social rules," such as keeping personal space, responding to others when they talk or greet your child, how to talk to adults/authority figures vs. peers.	☐	☐	☐
Difficulty problem solving and generating effective solutions on his/her own	☐	☐	☐
Has difficulty looking at people when talking or listening	☐	☐	☐
Has difficulty understanding facial expressions, gestures, or body language	☐	☐	☐
Has difficulty understanding another's perspective (point of view)	☐	☐	☐
Difficulty understanding abstract expressions/idioms (e.g., It's raining cats and dogs)	☐	☐	☐
Has difficulty staying on the subject when talking	☐	☐	☐
Does not tell enough background information for the listener to understand his/her story	☐	☐	☐
Overreacts to various social situations (e.g., has frequent conflicts)	☐	☐	☐

Social/Expressive Language	Often	Sometimes	Rarely
Has difficulty answering verbal questions	☐	☐	☐
Has difficulty asking questions	☐	☐	☐
Has difficulty using a variety of vocabulary words when talking	☐	☐	☐
Has difficulty describing things to people	☐	☐	☐

Social/Expressive Language cont.	Often	Sometimes	Rarely
Has difficulty getting to the point when talking	☐	☐	☐
Has difficulty putting events in the right order when telling stories or talking about things that happened	☐	☐	☐
Uses poor grammar when talking	☐	☐	☐
Has difficulty with using complete sentences when talking	☐	☐	☐
Has difficulty having a conversation with someone	☐	☐	☐

Auditory Processing/Listening/Receptive Language	Often	Sometimes	Rarely
Often needs directions repeated	☐	☐	☐
Sometimes misunderstands what is said	☐	☐	☐
Has trouble following spoken directions	☐	☐	☐
Background noise makes following verbal instructions more difficult	☐	☐	☐
Says “huh” or “what” in response to questions or needs extra time	☐	☐	☐
Does not respond to name when called	☐	☐	☐
Has difficulty remembering things people say	☐	☐	☐
Has difficulty understanding the meanings of words	☐	☐	☐