Wala'au THERAPY LLC
walaautherapy.com

2148 Awapuhi St., Hilo, HI 96720
Office: (808) 365-8128 Fax: (808) 961-6383

Child Intake Form

Please email completed form to: syd @walaautherapy.com

General Information

Child's Name: _____ Date of Birth:_____ Age: _____

Parent/legal guardian(s) names: _____

Child lives with both parents? Yes ☐ No ☐ if no, whom does the child live? _____

Home Address (Street, Town, State): _____

Mailing Address (P.O. Box, street, etc.): _____

Phone number: ( ) _____ - _____ Best time to contact *(circle)*: morning afternoon evening

Email address: _____ Primary Medical Doctor: _____

Please describe below present concerns/problems regarding your child:

_____

_____

_____

_____

Does your child have a diagnosis? Yes ☐ No ☐ If yes, diagnosis: _____

Has your child been seen previously by other therapists (Physical therapist, occupational, speech-language pathologist)?
Circle one. Yes No

If yes, where was your child seen? _____

What type of therapy services did your child receive (physical, occupation, speech/language)?

_____

How long did he/she receive therapy services? _____

How well is your child understood? (e.g. what percentage of the time?)

Parents: _____ Siblings: _____ Grandparents: _____

Other children: _____ Extended family: _____Unfamiliar adults _____

Prenatal/Birth History

Was your child born Full-term? Yes ☐ No ☐ If no, how many weeks? _____

Were there any complications during pregnancy or delivery? Yes ☐ No ☐

If yes, please explain: _____

Were there any medical problems detected at birth? Yes ☐ No ☐

If yes, please describe: _____

Birth weight: _____. Delivery: Vaginal _____ Cesarean: _____ N.I.C.U.: Yes ☐ No ☐

Medical History

Please check if your child had any of the following *(and if so, at what age)*

Seizures ☐ High fevers ☐ Chicken pox ☐ Whooping cough ☐ Tonsillitis ☐

Meningitis ☐ Pneumonia ☐ Encephalitis ☐ Chronic colds ☐ Asthma ☐

Heart problems ☐ Ear infections: ☐ Other: _____

Please explain any checked items here: _____

_____

Has your child had any serious illnesses, injuries, surgeries, or hospitalization? Yes ☐ No ☐

If yes, please explain: _____

Are immunizations current? Yes ☐ No ☐

Does your child currently take any medications? Yes ☐ No ☐

If yes, please describe name, dosage, frequency, and if any side effects.

_____

Does your child have any allergies: Yes ☐ No ☐

If yes, please describe: _____

Vision problems: Yes ☐ No ☐ Hearing difficulties: Yes ☐ No ☐

Has your child's hearing been tested by an Audiologist? Yes ☐ No ☐

Developmental History

Please list the ages your child achieved the following developmental milestones	
Skill	**Age Achieved**
Sat Independently	
Crawled	
Walked Independently	
Babbled	
Said first words	
Combined two words	
Produced sentences	

Did your child ever stop talking or stop saying words he/she used to say? Yes☐ No☐

If yes, please explain: _____

Current Communication Skills

Currently does your child *Please check the appropriate box*	**Yes**	**No**	**Sometimes/some**
Respond to his/her name when asked?	☐	☐	☐
Point to objects when asked?	☐	☐	☐
Follow simple directions?	☐	☐	☐
Get objects from another room when asked?	☐	☐	☐
Point to body parts when asked?	☐	☐	☐
Point to pictures when asked?	☐	☐	☐
Answer simple questions?	☐	☐	☐
Point to family members when asked?	☐	☐	☐
Understand prepositions *(e.g. in, under, on)*	☐	☐	☐
Understand color and size words *(e.g. red, big)*	☐	☐	☐
Engage in pretend or imaginative play?	☐	☐	☐

Any speech or hearing problems in the immediate or extended family? Yes☐ No☐
If yes, please explain:

_____

Please circle the phrases that describe how your child communicates (circle all that apply)

Pointing, other gestures	Touching or moving your hand towards object	Babbling
Manual signs	Single word	Two-word combinations
Simple 3-4 word phrases	Sentence with some errors	Grammatically-correct sentences
	Tells stories, explains what happened	

Does your child make his wants/needs known? _____ How? _____

Does your child exhibit unusual behavior? *Please explain*

_____

Sensory/emotional regulation

Does your child have….		
Difficulty calming self	☐ Yes	☐ No
Difficulty sitting still	☐ Yes	☐ No
Perseverate on objects or items	☐ Yes	☐ No
Eating issues	☐ Yes	☐ No
Sleeping issues	☐ Yes	☐ No
Difficulty transitioning from one activity to another	☐ Yes	☐ No
Complicated routines for bed, bath, mealtime	☐ Yes	☐ No
Cover his/her ears in response to otherwise typical sounds/noises	☐ Yes	☐ No
Difficulty with daily living activities *(e.g. tooth brushing, hair washing)*	☐ Yes	☐ No
Dislike having his/her hands dirty?	☐ Yes	☐ No

How does your child handle…..

Frustration? _____

Conflict? _____

Separation? _____

Unfamiliar people? _____

How many minutes/hours of television does your child watch per day? _____Electronics?_____

What motivates your child most? _____

What discipline methods work best? _____

Feeding History

Difficulty latching to bottle or breast? If yes, please explain below:		
Feeds self Independently? (from cup, spoon, bowl) If no, please explain below:	Yes ☐	No ☐
Does your child have any difficulty with feeding(e.g. choking with liquids, difficulty managing solids, trouble transitioning to textures, poor weight gain, reflex, etc. If yes, please explain below:	Yes ☐	No ☐
Is your child particularly selective about the foods he/she will eat (more than other children the same age?) If yes, please explain below:	Yes ☐	No ☐

What is your child's current diet (favorite and/or typical foods)?

_____

_____

Education/Additional services

Child's Current School: _____ Grade: _____

What type of classroom? (e.g. regular education, integrated, special day class)? _____

Receiving special services at school: Yes_____ No_____ If yes, what services?

_____

Does your child currently have an IFSP or IEP? _____

How does your child's teacher describe his/her performance? _____

Has the teacher expressed any concern? Yes_____ No _____ If yes, please explain:

_____

What are your child's favorite/preferred activities and toys? _____

_____

Is there anything not addressed above that you'd like to me know about your child?

_____

_____

_____