



NEW PATIENT INTAKE PACKET

OFFICE USE ONLY
DATE RECEIVED
ENTERED DATE

CONFIDENTIAL PERSONAL HISTORY

Childs Full Name: _____
Date of Birth _____ Age: _____ Pronoun: _____

Primary Guardian Name	Relationship:	
Primary Email:	_____	
Phone:	_____	
Preferred Method of Contact	Phone <input type="checkbox"/>	Email <input type="checkbox"/> Text <input type="checkbox"/>
Occupation:	_____	
Address:	_____	
	STREET	CITY STATE, ZIP CODE

Secondary Guardian Name:	Relationship:	
Primary Email:	_____	
Primary Phone:	_____	
Preferred Method of Contact:	Phone <input type="checkbox"/>	Email <input type="checkbox"/> Text <input type="checkbox"/>
Occupation	_____	
Address:	_____	
	STREET	CITY STATE, ZIP CODE

Emergency Contact	NAME	NUMBER	RELATIONSHIP
	_____	_____	_____

MEDICAL DIAGNOSIS		
Diagnosis:	Date:	Provider:
_____	_____	_____
Diagnosis:	Date:	Provider:
_____	_____	_____

List persons, ages, and relationships who are in home with child

Primary Insurance:		
Subscriber ID:	_____	Group # _____
Subscriber Name:	_____	
Secondary Insurance:		
Subscriber ID:	_____	Group # _____

Primary Health Care Provider(s)
Primary Care Provider: _____
Phone _____
Location _____

Other Specialist Providers Commonly Seen
Speciality/Name _____
Phone _____
Location _____

Other Ongoing Therapies?	Physical (PT) <input type="checkbox"/>	Speech (SLP) <input type="checkbox"/>	Occupational (OT) <input type="checkbox"/>	ABA <input type="checkbox"/>
Location _____	Location _____			
Type _____	Type _____			
Frequency _____	Frequency _____			
COUNSELING <input type="checkbox"/>	DIR/ FLOORTIME <input type="checkbox"/>			

Medications (current or past)		
Rx Name: _____	Date: _____	Reason _____
Rx Name: _____	Date: _____	Reason _____
Rx Name: _____	Date: _____	Reason _____

ALLERGIES:	
Allergen _____	Reaction _____
Allergen _____	Reaction _____
Allergen _____	Reaction _____

Any Medical Precautions? Please Explain

SCHOOL:	_____	Grade: _____
Teacher's Name	_____	
Type of Classroom	_____	Contact Info: _____

PERSONALITY PROFILE

What are your child's gifts and strengths?

What do you enjoy most about your child?

What are your child's primary interests and hobbies?

How is your child functioning in school? What are their strengths and weaknesses in school?

Does your child need support to attend school (such as 504 or IEP programs)? If so what is their educational diagnosis or accommodation?

What are your primary concerns regarding your child?

In order of priority, what behaviors are you seeking help for or better understanding of?
(Please be as specific as possible)

What time of day is the hardest and why?

In what ways have you had to accommodate for your child's individual differences?

Do you avoid certain situations at home, school or in the community?

GENERAL INFORMATION

Any complications, illness, or stress during pregnancy? Yes, please explain

Any complications during labor and delivery? Yes, please explain

How was your child delivered?

What was the gestational age of your child at birth?

What was your child's birth weight?

What is your child's birth order?

Your child's siblings (names and ages)?

Does your child have a history of ear infections? Yes, Please explain

Did/does your child have ear tubes? Yes, Please Explain

Has your child had any major injuries or hospitalizations? Yes, Please Explain

Any history of seizures? Yes, Please Explain

Any history of motor delays? Yes, Please Explain

Rolling

Crawling

Sitting

Walking

Any history of language delays? Yes, Please Explain

SLEEPING

Is sleeping, a concern, or was it ever? Yes, Please Explain

What time does your child go to bed?
What time does your child wake up?
Does your child wake during the night? Yes, Please Explain
What routines do you use to help return the child to sleep?
What mood is your child in generally in the morning?
Where does your child sleep?
How long does it take for your child to settle at night?
What is your bedtime routine with your child?
Does your child seem to require more or less sleep than other children? Yes, Please Explain
Does your child take naps? Yes, Please explain
Any other information around sleeping that we should know?

FEEDING
Was your child able to breast feed as an infant? Yes, how long?
If your child was bottle fed were there difficulties or concerns with feeding? Yes, Please Explain
Did your child have difficulty with latching or sucking as an infant? Yes, Please Explain
Was reflux and/or frequent spit up an issue? Yes, Please Explain

Was appetite or weight gain a concern? Yes, Please Explain

Do you consider your child to be a picky eater? Yes, Please Explain

Does your child have definite food preferences? Yes, Please Explain

Does your child have a list of under 20 foods they will eat? Yes, Please Explain

If less than 20 foods what food will the child eat regularly? (Please List)

Does your child have difficulty chewing a variety of food? Yes, Please Explain

Does your child have difficulty swallowing certain foods? Yes, Please Explain

Does your child over stuff their mouth during meals and/or snacks? Yes, Please Explain

Does your child appear to NOT notice when they have food on their face?

Yes, Please Explain

Is your child a messy eater? Yes, Please explain

Does your child eat with utensils? No, Please Explain

Does your child get up frequently during meals? Yes, Please Explain

Does your child have difficulty or immature patterns around feeding themselves?

Yes, Please Explain

Please describe typical mealtime with your child including WHERE and HOW they sit, HOW LONG they attend to a meal and what ROUTINES you use to get them to eat?

GROOMING/ HYGIENE

Does your child resist or dislike grooming activities?

Tooth Brushing

Nail Trimming

Hair Brushing

Blowing Nose

Face Washing

Hair Cuts

Please explain:

Does your child need excessive help with grooming tasks? Yes, Please Explain

Does your child have any special routines to assist them with completing a grooming task?

Yes, Please Explain

Does your child experience any discomfort with bathing or showering? Yes, Please Explain

Does your child require excessive help with Bathing or Showering? Yes, Please Explain

Does your child need a specific routine for grooming/hygiene? Yes, Please Explain

What happens if this routine is disrupted? Please Explain

How much assistance does your child need with the above tasks

100% assistance

25% Assistance

75% assistance

0% Assistance

50% assistance

DRESSING

Does your child have difficulty putting on any clothing items? Yes, Please Explain

Does your child have difficulty managing fasteners? Yes, Please Explain

Is your child picky about the texture of their clothing?

Does your child prefer minimal clothing even when it's cold outside?

Does your child wear too much clothing regardless of the temperature outside?

Do tags or seams bother your child?

Do you have special routines to help your child get dressed?

How much assistance does your child need with dressing?

100% assistance

25% Assistance

75% assistance

0% Assistance

50% assistance

Please explain any assistance required to help child get dressed.

TOILETING

Is your child toilet trained for bowel and bladder? No, Please Explain

Does your child experience toileting issues such as incontinence, bedwetting, constipation, etc.?

Does your child wear a type of incontinence support at night? Yes, Please explain

Do you have any routines you use to help your child use the toilet at an age appropriate level?

Does your child have difficulty completing the steps of toileting from clothing management to washing hands? Yes, Please Explain

How much assistance does your child need with toileting (including toilet hygiene)?

100% assistance

25% Assistance

75% assistance

0% Assistance

50% assistance

FAMILY/ SOCIAL

Do you limit family or social gatherings because of your child's behavior? Yes, Please explain

Does your child have difficulties at parties? (i.e. birthday) Yes, Please explain

Do you avoid leaving your child with familiar but not routine caregivers for childcare?

Do you have difficulty maintaining family relationships with other families? Yes, Please Explain

Are you limited in the types of activities or hobbies your family pursues due to your child's reaction?
Yes, Please Explain

Does your child have difficulty tolerating social touch or hugs from others? Yes, Please explain

Do you have routines you need to follow to help your child be successful in social situations?

Yes, Please Explain

COMMUNITY

Does your family avoid busy, unpredictable environments due to your child's response?

Yes, Please explain

Does your child lack safety awareness in the community? Yes, Please Explain

If age appropriate, does your child struggle with sleepovers? Yes, Please Explain

Does your child have difficulty sitting through public performances? Yes, Please Explain

Does your child demonstrate anxiety or stress in age appropriate movies? Yes, Please Explain

Do you avoid stores with your child? (i.e. grocery) Yes, Please explain

Does your child have difficulty standing in line? Yes, explain

When standing in line does your child have an excessive response when bumped? Yes, Please explain

Does your child seem to not notice being bumped at all? Yes, Please explain

SOCIAL BEHAVIORS

Does your child demonstrate aggressive behaviors? Yes, please describe

Does your child have tantrums that seem excessive? Yes, please describe

Is your child easily frustrated or overwhelmed? Yes, please describe response

Does your child appear excessively clingy? Yes, Please describe

Does your child escalate rapidly? Yes, Please describe

Do you notice atypical, repetitive behaviors in your child? Yes, please describe

Does your child have difficulty communicating their needs? Yes, Describe

Does your child seem not to hear their name being called? Yes please describe

PEER INTERACTIONS/ PLAY

Does your child have difficulty initiating with peers? Yes, please explain

Does your child struggle to play alone? Yes, Please explain

Does your child prefer sedentary play? Yes please describe

Does your child prefer excessively active play? Yes please describe

Does your child have difficulty playing with other children? Yes, please explain

Does your child destroy toys? Yes, please explain

Does your child's need for movement impair their interactions with peers? Yes, please explain

If your child seeks out movement to help themselves regulate, what are their preferred movements? (i.e. crashing to the ground, running, humming, flapping hands)

Does your child seek out specific playground equipment? Yes describe

Does your child take unnecessary risks when playing?

Does your child seem to get out of control at the playground or in an active environment?

Yes, Describe:

Does your child avoid messy activities? Yes, please explain

Does your child seem to have weaker muscles than their peers? Yes, explain

Is your child delayed in any gross motor skills compared to same aged peers (bike, hopping, skipping, etc.) Yes, Please describe

Does your child seem to want to control what they play with their peers? Yes, please explain

Does your child struggle to come up with ideas for play? Yes, please describe

FINE MOTOR SKILLS

Does your child have a hand preference? Yes, which hand

Does your child change hand preference when drawing/ coloring?

Does your child change hand grips frequently when coloring/drawing?

If age appropriate, is handwriting an issue?

Does your child avoid coloring/ drawing?

Does your child have difficulty sitting still during coloring/ writing?

Are there any other concerns you may have regarding your child or dynamics in your family in relation to your child that may not have been addressed in this questionnaire?

After reflecting on this questionnaire what GOALS do you have for your child? If you could wave a magic wand what would you wish for your child and your family?
Please be Specific in regards to challenges or behaviors

Who referred you to Blossom Therapeutics? _____

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT OUR INTAKE SPECIALIST
MONDAY THROUGH FRIDAY AT 541-617-8769 OR info@blossomtherapeutics.com

Thank you,
Blossom Therapeutics.