BLOSSOM THERAPEUTICS

120 SW Crowell Way Suite 100
Bend, OR 97702
PH: 541-617-8769 FX: 541-668-6772
Info@blossomtherapeutics.com

INTAKE PACKET

OFFICE USE ONLY
DATE RECEIVED
ENTERED DATE

CONFIDENTIAL PERSONAL HISTORY

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

Nickname: _____ Preferred Pronoun: _____

Legal Primary Guardian _____ Relationship to Child: _____

Primary Email: _____ Preferred Pronoun: _____

Phone: _____

Preferred Method of Contact: Phone ☐ Email ☐ Text ☐

Occupation: _____

Physical Address: _____
STREET CITY STATE, ZIP CODE

Legal Secondary Guardian: _____ Relationship to Child: _____

Primary Email: _____ Preferred Pronoun: _____

Primary Phone: _____

Preferred Method of Contact: Phone ☐ Email ☐ Text ☐

Occupation: _____

Physical Address: _____
(if different from primary)
STREET CITY STATE, ZIP CODE

Emergency Contact _____
(Non- Guardian)
NAME CONTACT NUMBER RELATIONSHIP TO CHILD

List Primary Residence, including persons, ages, and relationships who are in home with the 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) ☐ Speech (SLP) ☐ ABA ☐ Occupational (OT) ☐

Location _____ Location _____

Type _____ Type _____

Frequency _____ Frequency _____

COUNSELING ☐ DIR/ FLOORTIME ☐

MEDICAL DIAGNOSIS

Diagnosis:	Date:	Provider:
Diagnosis:	Date:	Provider:

ALLERGIES:

Allergen	Reaction
Allergen	Reaction
Allergen	Reaction

Medications (current or past)

Rx Name:	Date:	Reason
Rx Name:	Date:	Reason
Rx Name:	Date:	Reason

Any Medical Precautions? Please Explain

FAMILY MEDICAL HISTORY (Please check all that apply)

Autism ☐

ADHD ☐

Anxiety ☐

Other Genetic Conditions (please list)_____

School Information

Name: _____ Grade:

Teacher's Name: _____

Type of Classroom: _____ Contact Info: _____

PERSONALITY PROFILE
What are your childs gifts and strengths?
What do you enjoy most about your child?
How do you spend your time with your child?
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 childs individual differences?
Do you avoid certain situations at home 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 delievered?
What was the gestational age of your child at birth?
what was your childs birth weight
What is your childs birth order?

Your childs 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?

Please describe your child's sleep arrangement?

What position does your child generally sleep in?

Does your child wake during the night? Yes, Please Explain

What routines do you use to help them return to sleep?

What mood is your child 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?
Any other pertinent information around sleeping that we should know?

FEEDING
Is/Was your child able to breast feed as an infant? Yes, how long?
If your child is/was bottle fed were there difficulties or concerns with feeding? Yes, Please Explain
Does/Did your child have difficulty with latching or sucking as an infant? Yes, Please Explain
Is/Was reflux and/or frequent spit up an issue? Yes, Please Explain
Is/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
Is your child a messy eater? Yes, Please explain
Does your child get up frequently during meals? 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?

Communication
Does your child say "mama" and "dada" plus one or two other others? Yes, which words
Does your child wave goodbye? Yes, do they initiate or imitate?
Does your child point to objects? Yes do they look at you when pointing to object?
Does your child babble in such a way that mimics normal language?
Does your child understand simple questions? Example: Where is your nose? What does a dog say?

Does your child watch you when you talk to them?
Do you and your child have back and forth babble or cooing exchanges?

Movement/ Development
Can your child stack blocks?
Can your child pick up objects with thumb and forefinger?
Does your child attempt to feed self by picking up their food with hands?

Social/Emotional
Does your child play peek-a-boo, pat-a-cake?
Does your child like being read to and looking at picture books?
Does your child seem to be able to follow the pictures in the book? Does your child seem to notice when you leave the room by crying or fussing?
Does your child watch and imitate your actions like, smiling, following your gaze, etc?

COGNITIVE SKILLS
Does your child follow one step commands such as "give me the ball"?
Does your child watch and imitate older kids and adults?
Does your child repeat behaviors to get your attention by dropping a toy so you pick it up?

Does your child turn the pages in books?

MOVEMENT/DEVELOPMENT
Does your child bang together blocks or other toys/objects?
Does your child lift their hand when on tummy to look around?
Can your child roll from back to stomach?
Can your child roll from stomach to back?
Can your child sit alone?
Can your child move from lying down to sitting?
Can your child crawl?
If not crawling do they scoot in some sort of pattern?
Does your child pull themselves up to a stand using funiture or you?
Can your child stand alone?
Does your child walk? Yes, with what support?

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.