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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 ☐ Email ☐ Text ☐

Occupation: _____

Address: _____
STREET CITY STATE, ZIP CODE

Secondary Guardian Name: _____ Relationship: _____

Primary Email: _____

Primary Phone: _____

Preferred Method of Contact: Phone ☐ Email ☐ Text ☐

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) ☐ Speech (SLP) ☐ Occupational (OT) ☐ ABA ☐

Location _____ Location _____

Type _____ Type _____

Frequency _____ Frequency _____

COUNSELING ☐ DIR/ FLOORTIME ☐

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 childs gifts and strengths?
What do you enjoy most about your child?
What are your childs primary interests and hobbies?
How is your child functioning in school? What are their strengths and weakness 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 childs 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 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?
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 activites?

Tooth Brushing ☐
Hair Brushing ☐
Face Washing ☐
Nail Trimming ☐
Blowing Nose ☐
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 toliet 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 completeling 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 ☐
75% assistance ☐
50% assistance ☐
25% Assistance ☐
0% Assistance ☐

FAMILY/ SOCIAL

Do you limit family or social gatherings because of your childs 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 limitied in the types of activities or hobbies your family pursues due to your childs 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 childs response?
Yes, Please explain

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

If age appropriate, does your child struggle with sleepvers? 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 exessively 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 childs 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 frequenly when coloring/drawing?
If age appropropriate, is handwriting an issue?
Does your child avoid coloring/ drawing?
Does your child have difficulty sitting still during coloring/ writing?

SENSORY OVER-RESPONSIVENESS

My child is bothered by these aspects of clothing...

- ☐ seams in clothing
- ☐ tags in clothing
- ☐ socks
- ☐ wool clothing
- ☐ changing from long to short pants
- ☐ accessories
- ☐ elastic on clothing
- ☐ fuzzy or furry textured objects

My child is bothered by these self care aspects...

- ☐ washing/wiping face
- ☐ having hair cut/clipped
- ☐ getting dressed
- ☐ brushing teeth
- ☐ getting dirty
- ☐ having a messy mouth
- ☐ cutting toenails/fingernails
- ☐ hair washing and/or drying
- ☐ hair brushing and/or combing
- ☐ having crumbs around mouth
- ☐ having messy hands

My child is bothered by these tactile sensations...

- ☐ mud
- ☐ glue
- ☐ foods
- ☐ kissing
- ☐ light touch
- ☐ finger paint
- ☐ play dough
- ☐ haircare products
- ☐ coarse carpet

My child is bothered by these visual sensations...

- ☐ brightly colored patterns
- ☐ fluorescent lights
- ☐ visually cluttered environments
- ☐ fast moving images in movies or TV
- ☐ Busy pictures in books or complex artwork

My child is bothered by these smells...

- ☐ prefume/cologne
- ☐ cleaners/disinfectants
- ☐ air fresheners
- ☐ bath products
- ☐ soaps

My child is bothered by these aspects of food and eating ...

- ☐ salty foods
- ☐ soft foods
- ☐ lumpy foods
- ☐ new/unfamiliar foods
- ☐ slimy foods
- ☐ chunky soup
- ☐ spicy foods
- ☐ bread crust
- ☐ food prep and/or cleanup

My child is bothered by these sounds...

- ☐ clothing that makes noise
- ☐ doorbell ringing
- ☐ dog barking
- ☐ sirens
- ☐ alarms
- ☐ clock ticking
- ☐ concerts
- ☐ large gatherings
- ☐ parades
- ☐ gymnasiums
- ☐ sound of utensils against each other
- ☐ radio or TV in background
- ☐ flourescent lights
- ☐ constructions or landscape equipment
- ☐ water running in background
- ☐ toilet flushing
- ☐ appliances or small motors
- ☐ restaurants
- ☐ malls

My child is bothered by these aspects of movement...

- ☐ climbing activities
- ☐ experiencing of heights
- ☐ going up/down escalators
- ☐ chewing foods
- ☐ walking or climbing up stairs
- ☐ walking or standing on moving surfaces
- ☐ playing on playground swings and slides
- ☐ going on amusement park rides

SENSORY UNDER-RESPONSIVENESS

My child has a less intense response than others to...

- ☐ shots at the doctors
- ☐ bruises or cuts
- ☐ getting hurt
- ☐ too hot/cold objects
- ☐ being touched on the arm
- ☐ wet/dirty diapers
- ☐ dirt on themselves
- ☐ bumping into things/falling over objects

My child does not seem to notice...

- ☐ food or liquid on mouth
- ☐ the need to use the toilet
- ☐ feelings of hunger
- ☐ feelings of being full
- ☐ an object coming toward them quickly
- ☐ someone entering or leaving a room
- ☐ hands or face that are messy
- ☐ drooling or food that has fallen out of mouth
- ☐ over-filling mouth when eating
- ☐ strong or noxious odors
- ☐ activity in a busy environment
- ☐ materials or people in the room needed to complete an activity

SENSORY CRAVING

My child is contantly seeking...

- ☐ swinging
- ☐ twirling/spinning throughout the day
- ☐ movement without regards to safety
- ☐ jumping and crashing
- ☐ deliberate falling when running/ playing
- ☐ bumping, pushing, hitting, hugging others
- ☐ fidgeting, wiggling which interfere with daily activities
- ☐ movement in chair during class, meals, or other sitting situations
- ☐ pushing, pulling, or hanging off objects
- ☐ flapping/clapping hangs, biting self, or other repetitive actions
- ☐ changing from one activity to another without completion

My Child is constantly seeking...

- ☐ look at spinning objects
- ☐ stare at people or objects
- ☐ to be held
- ☐ to much affectionate touch with others
- ☐ to splash excessively during bath time
- ☐ to touch/feel objects
- ☐ excessive kissing
- ☐ fast changing TV or Movie segments
- ☐ flickering or blinking lights
- ☐ visually stimulating scenario (lava lamps, etc.)
- ☐ to touch others to the point of irritation
- ☐ vibrations from speakers, washers/ dryers
- ☐ head banging, hand biting, pinching, scratching, and hair pulling
- ☐ to put things to mouth

My Child is constantly seeking...

- ☐ to lick, suck, chew on non-food items
- ☐ to eat crunchy, chewy, or hard foods to the exclusion of other textures
- ☐ foods with strong flavors
- ☐ to smell people or pets
- ☐ to deliberatly smell or taste objects or toys while playing
- ☐ talking and has difficulty taking turns in conversation
- ☐ to speak in a loud voice
- ☐ to make a lot of noise during play activity
- ☐ to increase volume of TV or music
- ☐ to make strange sounds

POSTURE

My child does not..

- ☐ reach across their body to grab a toy
- ☐ have a preferred hand
- ☐ does not hold paper with other hand while cutting or writing

My child does not appear to have enough strength....

- ☐ to turn knobs/handles that require some pressure
- ☐ so has a loose grasp on objects like pencils or carrying things
- ☐ so holds thing tightly but cannot sustain to lift heavy objects
- ☐ so appears weaker than other children of the same age
- ☐ to hold a pencil the same way as most others

My Child has difficulties with these activies...

- ☐ balancing when bus or car stops quickly
- ☐ balancing during motor activities (biking, karate, etc)
- ☐ keeping good desk posture
- ☐ turning head to look instead of whole body
- ☐ standing or holding a particular position
- ☐ catching self when falling

My child...

- ☐ feels stiff and awkward when held
- ☐ keeps mouth open most of the time
- ☐ tires easily
- ☐ sits partly on/off the chair
- ☐ feels loose or floppy when I left them or move them around
- ☐ uses one hand or the other but avoids using hands together in play
- ☐ needs encouragement for heavy work

My child has difficulties coordinating the 2 sides of their body to...

- ☐ play rhythmic clapping games
- ☐ pump self of swing
- ☐ jump with both feet together
- ☐ ride a bicycle, tricycle, or other wheeled toy

My child has difficulties with the following visual activities...

- ☐ keeping track of place on page
- ☐ following a moving object with their eyes
- ☐ copying from a blackboard to paper

PRAXIS

My child has difficulty with these language activites

- ☐ being understood when they speak
- ☐ unable to follow 2-3 step verbal instructions

My child demonstrates difficulties in these motor activities...

- ☐ tasks with multiple steps
- ☐ following the steps of a recipe
- ☐ maintaining or copying rhythms
- ☐ hopping, jumping, skipping, or running
- ☐ sports or games
- ☐ riding a bike or tricycle
- ☐ climbing or playing on playground equipment
- ☐ learning exercise steps or routines
- ☐ learning new motor tasks
- ☐ balancing
- ☐ climbinng, jumping, walking on bumpy or uneven ground
- ☐ climbing on or over objects
- ☐ catching a ball

My Child...

- ☐ appears clumsy and seems not to know how to move their body
- ☐ approaches new motor activites in an overly cautious way
- ☐ is accident prone
- ☐ uses inefficient ways of doing things
- ☐ has difficulty forming a plan or idea for an action
- ☐ prefers sedentary play
- ☐ gets lost easily
- ☐ talks self through tasks
- ☐ tends to break toys/ objects when has problem using them

My child has difficulty with these fine motor activities

- ☐ playing with small manipulative toys (beads, legos)
- ☐ snapping fingers
- ☐ applying paste to a toothbrush
- ☐ blowing bubbles or whistles
- ☐ grasping a pencil or crayon

My child has difficulty with these school activities...

- ☐ drawing, coloring, or copying
- ☐ staying between the lines when coloring or writing
- ☐ cutting and pasting
- ☐ poor handwriting

My Child has difficulty with these daily tasks...

- ☐ licking an ice cream cone
- ☐ using a spoon or cup
- ☐ tying shoes
- ☐ fasteners
- ☐ handling eating utensils
- ☐ getting dressed/undressed
- ☐ placing arm/leg correctly in clothing

My Child...

- ☐ is a messy eater
- ☐ eats or dresses slowly
- ☐ puts clothes on backwards or inside out
- ☐ looks disheveled

SENSORY DISCRIMINATION

My child has trouble finding...

- ☐ utensils on the table or in the sink
- ☐ familiar face in the crowd
- ☐ information on a blackboard
- ☐ objects in distracting backgrounds (shoes in messy room)
- ☐ things that are moving from those that are not
- ☐ desired item in a drawer or on a shelf
- ☐ desired garment in a closet
- ☐ socks that match
- ☐ the difference between fingures that are similar (ie. b and d, or + and x)

My child has trouble judging...

- ☐ the amount of force needed for a task
- ☐ the amount of pressure with markers, crayons and glue sticks (breaks, or flattens)
- ☐ timing and distance
- ☐ where food is in their mouth
- ☐ if they are moving or the things around them are moving

My child has trouble distinguishing (without looking)....

- ☐ objects in pockets
- ☐ what is in their hand
- ☐ what is touching them
- ☐ buttons and button holes

My Child...

- ☐ tends to examine toys by touching and feeling rather than looking
- ☐ examines things by putting them in their mouth (over age of 1.5 years)

My child has trouble distingushing

- ☐ location of sounds
- ☐ what is said
- ☐ specific sounds that are similar
- ☐ the words to a song
- ☐ taste of different foods

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.