# Intake/Parent Questionnaire

Children's Therapy Associates, Inc.

Please provide us with the following information so we can best serve your child.

Today's date: _____

Name of Person completing this form: _____

Relationship to child: _____

Name of Child: _____ Birth date: ____ / ____ /____

Parents Names: _____

Marital Status: _____ Language(s) spoken: _____

Siblings Names and ages: _____

_____

Phone: (Home) _____ (Work)_____ (Cell)_____

Place of employment: _____

Home Address: _____ Apt#:_____

City: _____ State: _____ Zip: _____

Who referred you to CTA?: _____

Why are you seeking CTA services? _____

_____

Child's physician(s): _____

Other health professionals working with your child: _____

_____

Other Agencies that assist you or your child: _____

_____

Insurance/Medicaid: ☐ Yes ☐ No

List current school or childcare provider: _____

_____

List previous school/daycare experiences: _____

_____

Describe your child's development as compared to other children of the same age: _____

_____

_____

What are your child's strengths? _____

_____

_____

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What things are difficult for your child? _____

_____

_____

Please list your child's favorite play activities/toys: _____

_____

_____

Describe how your child gets along with other children: _____

_____

_____

Does your child have difficulty understanding or following directions? _____

_____

_____

Is your child a picky eater? ☐ Yes ☐ No If yes, how? _____

_____

_____

What are your child's favorite foods?: _____

_____

What foods does your child dislike?: _____

_____

Describe mealtime routines or concerns: _____

_____

Describe bedtime routines or sleep concerns: _____

_____

Please describe any toileting concerns: _____

_____

Does your child seem overly sensitive to noises, lights, crowds/groups, textures/touch, clothing etc.?:

☐ Yes ☐ No If yes, describe: _____

_____

Does your child experience frequent falls or injuries?: ☐ Yes ☐ No If yes, describe: _____

_____

Do you feel your child has an unusually high or low pain tolerance?: ☐ Yes ☐ No If yes, describe: _____

_____

Does your child seem to have difficulty manipulating toys/objects: ☐ Yes ☐ No

Does your child enjoy playground activities such as swings, slides etc?: ☐ Yes ☐ No

Do you have any difficulties managing your child's behavior/attention or activity level? ☐ Yes ☐ No If yes, describe: _____

_____

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Does your child do anything that you feel may be unusual?: _____

_____

_____

Has there been any significant changes in the family (change in marital status, moves, deaths etc.)?:

_____

## HISTORY

☐ Full term ☐ Premature (note # of weeks) _____ ☐ Natural delivery ☐ C-section

Birth weight: ____ lbs. ____ oz. Place of Birth: _____

Please note anything unusual or list any complications during pregnancy or delivery: _____

_____

Breastfed ☐ Yes ☐ No How long? _____ Formula? ☐ Yes ☐ No

Nursing difficulties? ☐ Yes ☐ No Infant feeding issues? _____

Describe any medical problems, illnesses, or accidents your child has experienced: _____

_____

How old was your child when they:

rolled over: _____ sat unassisted: _____ crawled: _____

walked: _____ vocalized (mama/dada): _____ spoke words: _____

toilet trained: _____ fed self: _____ dressed self: _____

List any medication your child receives: _____

Have you had your child's vision or hearing tested?: ☐ Yes ☐ No If yes, please list when, where and describe the results: _____

Do you have any vision or hearing concerns?: ☐ Yes ☐ No Describe: _____

_____

Has your child experienced frequent ear infections: ☐ Yes ☐ No How often?: _____

How were these treated?: _____

Does your child grind their teeth at night/day? ☐ Yes ☐ No Do they clench their jaw? ☐ Yes ☐ No

Please describe any family history of health, emotional or learning difficulties: _____

_____

Please share any other information that you feel will be helpful to us in working with your child and family:

_____

_____

Note things you would like to learn more about to help your child/family: _____

_____

_____

_____

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