move . play . grow

New Patient Intake

Today's Date: _____

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

First Name Last Name

Age: _____ Sex: M / F Adopted? Y / N

Years Months

Parent/Guardian 1 Completing this questionnaire: _____

First Name Last Name

Parent/Guardian 1 Completing this questionnaire: _____

First Name Last Name

How did you hear about POTS? (circle)
Friend / Relative / School / Physician / Google / POTS Website / Social Media / Yelp / Other:_____

Who can we thank for referring you to POTS? _____

What brings you to POTS today?

_____

_____

_____

What do you hope to gain from this evaluation?

_____

_____

_____

What are your goals and aspirations for your child?

_____

_____

_____

Has your family experienced any recent crisis or stress that you feel is important to your child's development at this time?

_____

_____

_____

Did either parent or any relative experience the same difficulties as your child? Please Explain:

_____

_____

_____

Family

Parent #1 Name: _____

First Name Last Name

Address: _____

Street Name City State Zip Code

Cell Phone Number: _____ Email: _____

Occupation: _____

Parent #2 Name: _____

First Name Last Name

Address: _____

Street Name City State Zip Code

Cell Phone Number: _____ Email: _____

Occupation: _____

Siblings:

Name	Age	Gender	School

Pediatrician

Pediatrician's Name: _____
First Name Last Name

Address: _____
Street Name City State Zip Code

Phone Number: _____ Email: _____

Website: _____

How long has your child been under this physician's care? _____

Has your child been diagnosed as having any medical or educational condition? Please explain:

_____

_____

_____

Who made the diagnosis and when was it made? _____

_____

Medical History

Birth Weight: _____ lbs _____ oz

Apgars: _____ Pregnancy: (circle) Full Term / Premature / IVF

Mother's health during pregnancy? _____

_____

Problems encountered during pregnancy (illness, injury, stress, anemia, medications, etc):?_____

_____

Labor:

Total length of labor: _____ Induced Birth? Y / N Breech Presentation? Y / N

Delivery**:** Vaginal / Cesarean / Forceps / Anesthesia (other than epidural)

Problems encountered during labor and delivery:

_____

_____

_____

Neonatal History: (check all that apply)

____ Jaundice ____ Cyanosis ____ Limpness

____ Stiffness ____ Oxygen ____ Congenital defects

____ Transfusions ____ Tube feedings ____ Immobilization

Were there any feeding difficulties in the first month?_____

_____

Were there any other problems encountered in the first month?_____

_____

List illnesses, injuries, or surgeries the child has had and age at the time of illness:_____

_____

Does your child have….	Yes	No	
Allergies?			Type:
Ear Infections?			Frequency:
High Fevers?			Frequency:
Seizures?			Frequency:

General health at present: (circle) Good / Fair / Poor

Describe your child's health at present:_____

_____

List current medications and why they've been prescribed:_____

_____

Are there any medical precautions we should be aware of?_____

_____

Please indicate which specialists your child has seen:

	Name	Date(s) Seen	Phone Number	Findings
Pediatric Neurologist				
Developmental Pediatrician				
Learning Specialist				
Psychologist				
Psychiatrist				
Speech Pathologist				
Audiologist				
Physical Therapist				
Occupational Therapist				
Developmental Optometrist				
Ophthalmologist				
Nutritionist				
ENT				
Child Study Team				
Other				

Developmental History

Does your child prefer one hand over the other?(circle) Yes / No / I don't Know

(circle) Right Handed / Left Handed

Were any of the following milestones delayed?	Currently Unable	Delayed	Met on Time	I don't know
Rolled by 7 months				
Crawled by 10 months				
Reached by 6 months				
Walked by age 13-16 months				
Finger fed by 16 months				
Drank from open a cup by 18 months				
Ate with spoon by 2 yr				
Draw a circle by 3 yr				
Dressed self by 3 yr				
Clothing fasteners by 4 yr (tie bow by age 6)				
Toilet trained by 4 yr				
Cut with scissors by 4 yr				
Use knife for cutting by 5 yr				

Comments:_____

_____

_____

Does your child…	Yes	No	Unable	Not Sure
Like to run?				
Pedal a 2 wheel bike?				
Pedal a trike?				

Check all that describe your child as an infant:

____ Fussy, irritable ____ Quiet ____ Good, non-demanding ____ Resisted being held
____ Passive ____ Active ____ Liked being held ____ Irregular sleep patterns
____ Slept well ____ Floppy ____ Tensed muscles when being held
____ Overly active, never still unless sleeping

Comments on your child's infancy and early childhood:_____

_____

_____

Please comment on your child's behavior:_____

_____

_____

Approximate Age at which your child did the following:

	Years	Months
Raised head		
Pulled to standing		
Crawled on hands and knees		
Stood alone		
Sat alone		

	Years	Months
Walked		
Babbled		
Spoke in sentences		
Said first word		

Your general impression of your child's motor development:	Advanced	Normal	Slow
Gross motor: (running, jumping, ball play)			
Fine motor: (beading, lacing, cutting with scissors)			
Handwriting/coloring skills:			
Speech			
Language			
Hearing			

Please describe your child's skills:_____

_____

Daily Schedule

My child is in school/day care from the hours of: _____ to _____.

Which Days? ___Monday ___Tuesday ___Wednesday ___Thursday ___Friday ___Saturday ___Sunday

Please describe your child's morning routine (typical school day)._____

_____

_____

_____

_____

What factors most interfere with a smooth morning?_____

_____

_____

Provide an overview of your child's usual after-school routine._____

_____

_____

_____

_____

What are the biggest deterrents to a smooth evening?_____

_____

_____

How does your child choose to spend his/her free time at home?_____

_____

_____

Describe your child's play. Does your child play appropriately with toys? What are his/her favorite play activities and themes?_____

_____

_____

How long does it take your child to fall asleep once put to bed? Please describe your child's bedtime routine. What tends to relax or over-stimulate him/her at night? Does your child need someone nearby to fall asleep?_____

_____

_____

How does your child cope with weekends (e.g., more physically active, stays in front of the TV, play date with friends, type of demeanor compared to week days)?_____

_____

_____

What is his/her mood like when he/she returns to school after the weekend?_____

_____

_____

Behavior and Social Skills

Who is primarily responsible for discipline and rule setting at home? _____

What methods are most effective? How does your child respond to discipline?

_____

_____

How often does your child tantrum? Please describe.

_____

_____

Have you observed any head banging or self-destructive behavior? Y / N

How does your child respond to authority figures outside of the home?

_____

_____

How does your child respond to structure and routine? Please elaborate:

_____

_____

Does your child have a “best friend”? Y / N

Older or Younger? ____Older ____Younger ____Same age

Is your child attuned to social cues? Is he/she socially appropriate (at school, home, play date, party)?

_____

_____

How does your child do with one-on-one play dates? Does he/she request them?

_____

_____

Are you concerned with your child’s ability to function at birthday parties, other group or crowded situations? (e.g. guests at home, visiting friends or relatives, youth group, synagogue, church, mall, movie theater, etc.)

_____

_____

Occupational History

What are your child's favorite activities and what does he/she love doing the most?

_____

_____

What do you see as your child's strengths? What are your child's greatest accomplishments?

_____

_____

What does your child dislike the most?_____

_____

_____

In one sentence how would you describe your child?_____

_____

In one sentence how would you describe yourself?_____

_____

Please describe a typical day for your child from waking till bedtime (including whether it is difficult for your child to get to sleep and stay asleep). Please add any information that will help us know your child better:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Level of Concern

What is your primary concern for your child that brings you to POTS today?

_____

_____

Overall what is your level of concern for your child?

Mild ____1 ____2 ____3 ____4 ____5 **Moderate** ____6 ____7 ____8 ____9 ____10 **Severe**

Overall how often do you experience these difficulties with your child?

Times per week: ____1 ____2 ____3 ____4 ____5 ____6 ____7 ____8 ____9 ____10

Other: _____

Approximately when did this situation start and is it getting better, worse or staying the same?

_____

_____

Demeanor (check all that apply):

____ Mostly Quiet ____ Usually Happy ____ Has positive self-esteem

____ Shy ____ Anxious ____ Aggressive

____ Easily frustrated ____ Cries often

Activity Level (check all that apply):

____ Tires easily ____ Overly active ____ Lethargic: moves slowly

____ Talks constantly ____ Restless ____ Constantly on the go

____ More active than children the same age Other:_____

Cooperation (check all that apply):

____ Cooperative ____ Stubborn ____ Resistant to change ____ Does not listen

____ Over reacts ____ Fights frequently ____ Difficulty transitioning ____ Gets stuck

____ Does not listen ____ Interrupts frequently ____ Frequent temper tantrums

____ Sudden outbursts ____Verbally aggressive ____ Difficulty separating from primary caretaker

Other: _____

Focus and Attention (check all that apply):

____ Engages in activity a reasonable length of time ____ Poor attention span

____ Overly focused, misses what is going on around him/her ____ Impulsive

____ Distractible ____ Poor memory Other: _____

Sensory Motor (check all that apply):

____Compulsive rituals ____ Motor or vocal tics ____ Nervous habits ____ Falls often

____ Rocks self frequently ____ Unusual postures ____Gets stuck

____ Self stimulation ____ Clumsy ____ Vocal tics

____Difficulty learning new tasks ____ Unaware of food on face/sloppy at mealtime

Please describe any unusual behaviors you would like us to be aware of:

_____

_____

_____

_____

Self-care Skills

Eating Skills

Feeds Self: (circle) Most / Some / All

Skill with eating utensils:	Fingers	Spoon	Fork	Knife	Cup
Level of proficiency: (1) Dependent to (5) Highly Proficient					

Is your child a messy eater? Please explain:

_____

_____

Does your child object to certain foods, tastes, and textures? Please explain:

_____

_____

Dressing	Remove	Put On
Undershirt		
Socks		
Shirt		
Shoelaces		
Underpants		
Shoes		

Dressing cont.	Remove	Put On
Pants		
Buttons		
Snaps		
Velcro Closures		
Zippers		
Jacket		

Anything else you would like us to know about dressing?

_____

_____

Bathing

Does your child take a bath? Y / N Shower? Y / N Does your child enjoy it? Y / N

Is your child sensitive to the temperature of the water? Y / N

How much assistance does your child need to wash their body?

_____

_____

How much assistance does your child need to wash:	A lot	Some	None
Face			
Hair			
Dry off			

Toilet Training

Is your child toilet trained? (check) ____ Days ____ Nights ____ Neither

Age Trained for days: _____ Age Trained for Nights: _____

Please tell us about any toilet training issues?_____

_____

Please share any concerns you have about your child's dependence, independence, or resistance to self-care tasks at home or in school? _____

_____

_____

Speech and Language History

Please describe your concerns:

_____

_____

When were you first concerned?

_____

_____

What strategies have you employed to help remediate the problem?

_____

_____

Present oral motor/communicative behavior?

_____

_____

If your child communicates differently at home, daycare or school? Please explain:

_____

_____

Family history of communication or speech problems:	Family Member
Speech/Oral Motor Problems	
Stuttering (or cluttering)	
Pacifier use	
Thumb sucking	
Learning problems	
Cleft/lip palate	
Neurological problems	

At what age did your child begin to…	Years	Months
Babble		
Say First Words		
Combine Words		

What were your child's first words?_____

What were your child's first phrases or sentences?_____

Does your child have difficulty with:	Yes	No	Comments:
Pronouncing sounds/words			
Forming sentences			
Following directions			
Remembering			
Stuttering			
Vocabulary			
Voice quality			
Being understood by others			

How much do you understand of your child's speech? _____%

How much do others not familiar with your child? _____%

Explain:_____

_____

_____

How does speech, language, and oral motor deficits impact on your child's ability to participate in school, at home and in the community?

_____

_____

Feeding History

Did your child have sucking difficulties at birth? Y / N

Was/is your child breastfed or bottle fed? (circle) Breastfed / Bottle Fed / Both

During feeding, did/does your child have difficulty with:	Yes	No	Comments:
Sucking			
Food Tastes			
Chewing			
Food Textures			
Swallowing			
Food Temp.			
Spitting out			
Vomiting			
Cup Drinking			
Gagging			
Drooling			
Handling Utensils			
Coughing			
Choking			

Has your child had a swallow study or video-fluoroscopy? If yes, when and where?

_____

_____

When did your child…	Years	Months	Comments:
Transition from bottle to cup drinking			
Transition from baby to table food			
Feed self independently			

What does your child currently drink from?(check) _____ Sippy cup ____ Straw ____ Open Cup

Any difficulties with positioning or sitting at the table to support feeding?

_____

_____

How long does it take your child to eat a typical meal?

_____

_____

Does your child have food allergies? If yes, to what?

_____

_____

Educational History

Current school: _____

Grade: _____ Teacher: _____

Prior Schools: _____

Has your child been in a special classroom, attended remedial or enrichment classes, or received tutoring? Please describe.

_____

_____

In what areas does he/she excel?

_____

_____

What areas are challenging for your child?

_____

_____

What are the school's primary concerns?

_____

_____

Is there any discrepancy between your impression of your child and the school's?

_____

_____

Does your child comprehend directions as well as other children? Y / N Other: _____

Has your child had to repeat a grade? Y / N Comments:_____

Child's level of intelligence in comparison to other children? (check)

____Above average ____Twice Exceptional ____Average ____Below Average Other:_____

Current Placement: ____Regular Class ____Special Education Class ____Has an 504

____ Has an Individualized Education Plan (IEP) ____Gifted

Rate your child's school academic experiences overall:

	Academic Good	Academic Average	Academic Poor
Preschool			
Kindergarten			
Grade 1			
Grade 2			
Grade 3			
Grade 4+			
Preschool			

Rate your child's student's skills overall:

	Student Skills Good	Student Skills Average	Student Skills Poor
Preschool			
Kindergarten			
Grade 1			
Grade 2			
Grade 3			
Grade 4+			
Preschool			

Teacher describes the following as significant classroom problems (check all that apply):

____Moves constantly
____Shouts out
____Does not respect the rights of others
____Does not wait to be called on
____Difficulty participating in circle time
____Difficulty participating in small groups
____Difficulty paying attention during academic time
____Difficulty with field trips/special assemblies/movies/class discussion
____Does not wait for turn
____Frequently gets up and walks around
____Does not cooperate well in groups
____Typically does better 1:1
____Difficulty with individual work
____Difficulty navigating free play
____Other:_____

I am attaching a picture of my drivers license _____*initial*

I am attaching my child's prescription _____*initial*

I am attaching a photo of my child _____*initial*

Date: _____Signature:_____

Please return this completed form to mary@potsot.com or fax to 201-837-9465.