



# Kinder Blossoms TheraPlace

Enriching Lives, Inspiring Minds

## New Client Intake Form

Background Information	
Child's Name:	Child's DOB and age:
Parent's/Guardian's Name:	Phone:
E-mail:	Current Address:
School: Grade:	Siblings (# of and ages):
Diagnosis (if one) and date of onset:	Development Age (if different from DOB):
School-based Therapy? Yes/No	Any special instruction/established IEP at school:

Referral Information
Referral Source:
Reason for Referral:
Caregiver Primary Concerns & Goals:
Child's Strengths & Interests:

## Medical History

Length of pregnancy with this child: \_\_\_\_\_

Any difficulties during pregnancy (check all that apply)?

- Excessive illness
- Exposure to drugs/alcohol
- COVID-19

- Emotional upsets
- Other \_\_\_\_\_

How would you describe the labor (check all that apply)?

- Easy Vaginal Birth
- Vaginal Delivery
- C-section Delivery
- Induced Labor
- Home Delivery
- Hospital Delivery
- Other \_\_\_\_\_

Concerns with early development (check all that apply)?

- Normal, no problems
- Difficulty with feeding/sucking
- Chronic ear infections
- Frequent fevers
- GERD/reflux
- Congenital Differences
- Cleft Lip and/or Palate
- NICU (Length of Stay:\_\_\_\_\_)
- Other \_\_\_\_\_

Current Prescribed Medications: \_\_\_\_\_

Any Current Food Allergies: \_\_\_\_\_

Medical Precautions: \_\_\_\_\_

Has the child ever had an operation or been hospitalized? If yes, please provide date(s), surgery and hospital: \_\_\_\_\_

\_\_\_\_\_

Child's Most Recent Hearing Test: \_\_\_\_\_

Child's Most Recent Vision Test: \_\_\_\_\_

Past/Currently receiving services from other health care professionals (check all that apply)

- Occupational Therapy
- Speech & language Therapy
- Physical Therapy
- Behavior Counseling
- Nutritionist
- Other \_\_\_\_\_

## Developmental History

Please check all the milestones that your child achieved:

- Rolling
- Sitting Independently
- Crawling
- Pull to Stand
- Walking
- First word
- Finger Feeding
- Feeding with Spoon
- Cutting with Scissors
- Riding a Bike

Were milestones met within a typical age or delayed? \_\_\_\_\_

**Please check any statements that describe your child:**

Areas of Concern	Comments
<input type="checkbox"/> Fine Motor Skills (grasp and manipulation of objects, finger dexterity).	
<input type="checkbox"/> Gross Motor Skills (walking, ball skills, playground equipment access)	
<input type="checkbox"/> Visual Motor Skills (writing legibility, copying/drawing shapes, hand dominance, cutting).	
<input type="checkbox"/> Visual Perceptual Skills (color & letter recognition, left-right discrimination).	
<input type="checkbox"/> Self- Care (bedtime routines, dressing, bathing, eating, toileting, nail/hair cutting).	
<input type="checkbox"/> Sensory Motor (difficulty with sitting still, organization of body in space, bilateral coordination).	
<input type="checkbox"/> Organizational skills (transitions, routines, planning, attention, following directions).	

<input type="checkbox"/> Sensory Regulation (sensitivity to/seeking movement, touch and sound).	
<input type="checkbox"/> Play skills/social skills (repetitive play,difficulty making friends/playing with peers)	
<input type="checkbox"/> Emotional concerns (easily frustrated, anxiety, poor self-esteem)	
<input type="checkbox"/> Other	

\_\_\_\_\_  
Parent/Legal Guardian Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date