Kids Place
THERAPY SERVICES, LLC
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INTAKE QUESTIONNAIRE

Thank you for taking the time to fill out this questionnaire regarding your child. If you have any questions, please call 630-347-1702.

Child's name: _____ DOB: _____

Person completing this form: _____

Child's diagnosis (if applicable): _____

Diagnosis made by and diagnosis date: _____

Name of school/daycare: _____

Please list any other special services your child receives: _____

Please list the persons and pets living in the child's home.

_____

What are your child's strengths/interests? _____

What is your main concern? _____

Please answer the following: (Please explain below)

	Yes	No		Yes	No
Was pregnancy full term?			Ear Infections?		
Any medications taken during pregnancy?			Ear tubes?		
Any complications with delivery?			Hearing aids?		
Any special care required at birth (i.e. oxygen, intubation)			Hearing evaluation completed? When?		
Any diagnosed genetic disorder?			Eye glasses?		
Is your child adopted?			Vision evaluation completed? When?		
Frequent colds, respiratory infections, asthma or sinus problems?			Serious illness or injury?		
History of seizure(s)?			Any medical testing (i.e. MRI, EEG, EKG)?		

_____

_____

_____

Please list current/regular medications: _____

Allergies/Precautions/Restrictions: _____

Does your child exhibit negative behaviors outside of those expected for his/her age? Please circle.

Refusal to do difficult tasks Hitting or throwing Emotional Shutdowns
Tantrums Difficulty separating Short attention
Other: _____

Questions Related to your Child's Development

Child's name _____

Please circle the area(s) in which you have concerns?

Not talking	Understanding directions	Ability to express himself
Understanding what child says	Stuttering	Social Skills
Feeding	Oral Motor Skills	Auditory Processing

Speech:

Does your child use words to communicate? Yes/No

How much of the time do you understand your child's speech?

0-25% 26-50% 51-75% 76-100%

Do you understand more or less as sentence length increases?

Receptive Language:

Can your child point to or touch a common object that you name? Yes/No

Can your child understand simple routine directions (e.g. sit down, come here, stand up)? Yes/No

Can your child follow multi-step directions (e.g. put your shoes on, get a book and sit down)? Yes/No

Expressive Language:

Does your child try to gain your attention to show you or ask you for things? Yes/No

Circle the highest level in which your child is effectively communicating:

Gestures Sounds Words Phrases Sentences Conversation

Social Skills:

Is your child able to make/keep friends easily? Yes/No

Does your child initiate play with peers? Yes/No

Does your child use eye contact? Yes/No

Does your child take turns? Yes/No

Does your child imitate play? Yes/No

Feeding/Oral Motor:

Does your child put toys/objects in his or her mouth? Yes/No

Does your child drool? Yes/No

Is your child a picky eater? Yes/No

Does your child cough when drinking or eating? Yes/No

Has your child had a video swallow study or been seen by another facility for feeding? Yes/No

Please explain: _____

Does your child eat a variety of foods in the following categories?

Meat: Yes/No Bread/starches: Yes/No Fruits: Yes/No Vegetables: Yes/No Dairy: Yes/No

Anything else you would like to share about your child's communication or eating habits?

_____

_____

My goal for my child's speech/language/feeding development is ...

_____

Child's name _____

Please circle any concerns you have about your child's development:

Overall Coordination	Independence with self-care	Sensory Issues
Attention	Interaction with others	Play skills
Behavior	Variety of foods accepted	Fine motor skills
Motor Planning	Problem Solving	Visual motor skills

Self-Care skills:

Does your child need help with dressing? Yes/No
Can your child complete snap, zippers, and buttons? Yes/No
Can your child pick out his/her own clothing? Yes/No
Can your child tie his/her own shoes? Yes/No
Does your child enjoy bath time? Yes/No
Does your child use a spoon and fork to self feed? Yes/No
Does your child follow morning or evening routines with few reminders? Yes/No
Is your child rigid about his/her routine? Yes/No
Please describe any concerns:

_____

_____

Sensory:

How does your child respond to a change in environment, such as going to school or visiting friends or relatives? _____
Does your child respond negatively to busy environments such as the grocery store or mall? Yes/No
Are there certain textures that bother your child (e.g. clothing, tags, toothpaste, foods, grass, sand)? Yes/No
Please describe any sensory related concerns:

_____

_____

Describe your child's activity level:

_____

_____

Do you have any concerns with your child's attention? Yes/No
If yes, please describe:

_____

_____

Is there anything else you would like to share about your child's development?

_____

_____