



info@learningcharms.com
TIN: 26-4353232

Occupational and Speech Therapy Client Intake Form

Today's Date: _____

Child's Name: _____ Parent(s) Name: _____

Date of Birth: _____ Phone: _____

Age: _____ Address: _____

Parent Email Address: _____

Primary Physician: _____ Physician Group Name: _____

Diagnosis (if any): _____ Medications (if any): _____

Child lives with (check all that apply): Mother Father Brother(s) Sister(s) Grandparent(s) Guardian

Marital Status of Parent(s): Single Married Divorced Separated Widowed

Mother's Place of Employment: _____ Mother's mobile: _____

Father's Place of Employment: _____ Father's mobile: _____

Health Insurance: Yes No

Health Insurance Company: _____

Who we may thank for referring your child for occupational or speech therapy services?

Has child ever received occupational therapy? Yes No If yes, please state where: _____

Has child ever received speech therapy? Yes No If yes, please state where: _____

Please describe your concerns about your child's development:

Developmental and Medical History:

1. Did water break more than 24 hours prior to delivery? Yes No
2. Develop toxemia/high blood pressure? Yes No
3. Complications during labor or delivery? Yes No
4. Mother's age at delivery: _____

Birth History:

1. Was child full term? Yes No Please list at how many weeks child was born: _____
2. What was the child's weight? _____
3. Was child born cesarean? Yes No
4. Was child born in breech position? Yes No
5. Did child require hospitalization? Yes No If yes, please describe: _____

Child's Health:

1. Any known allergies? Yes No If yes, please describe: _____
2. Any diet restrictions? Yes No If yes, please explain: _____
3. Has child had chronic ear infections in the past? Yes No

Please return to Learning Charms via fax: 980-229-4642 or email: info@learningcharms.com

4. Did child require PE tubes? Yes No
 5. Please list any medical or surgical procedures to date:
-

Developmental Milestones:

Age Able to Perform Without Help:

Started babbling	
First word spoken	
Started eating with fingers (finger foods)	
Fed self with spoon	
Drank from a sippy cup	
Rolled over	
Sat without help	
Crawled	
Walked	
Potty trained	
Rode a bike without training wheels	

Self Help Skills:

1. Does child put on underwear, shirt and pants without help? Yes No
2. Does child tie shoes without help? Yes No
3. Does child consistently align zipper without help? Yes No
4. Does child consistently button without help? Yes No
5. Does child eat without help? Yes No
6. Given supervision, does child bathe/shower without help? Yes No
7. Does child put on socks without help? Yes No

Education and School History:

1. Where does your child currently attend school? _____
2. What grade? _____
3. Does your child receive any special support during his/her day (e.g. resource, speech therapy, counseling, etc):
 Yes No If yes, please list: _____
4. Has your child received any formal educational testing? Yes No If so, what and when?

5. In your opinion, what are your child's strengths?

6. What are your concerns about your child?

7. What have you been told by other professionals (doctors/teachers/etc) about your child's abilities and needs?

8. What do you hope your child will achieve by receiving services at Learning Charms?

Learning Charms Waiver

I understand that Learning Charms assumes no responsibility for injuries or illnesses which my child may sustain as a result of participation in any day camps, classes, individual tutoring, therapy, the use of any equipment, exercise, or other activities. I acknowledge that I assume the risk for any and all injury and illness which may result from participation in these. In consideration of the privilege of participating at Learning Charms, I hereby voluntarily release and discharge the Learning Charms and its agents, servants and employees, and contractors from any and all claims for injury, illness, death, loss or damage which may be suffered as a result of participation in these activities. A parent/responsible party must discuss with the Learning Charms director any special conditions or circumstances involving their child prior to registration. I agree to have a physician examine my child within a reasonable time prior to the start of the program/activity to determine my child is free of communicable disease and has not been exposed to such. I hereby give permission to the medical personnel selected by Learning Charms staff to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes and to provide or arrange necessary related transportation for me/my child in the event of medical emergency. I understand that no accident/medical insurance is provided with this activity.

I have read, and agree with the waiver

Parent Signature

Parent Printed Name